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ABSTRACT

This first year progress report describes a comprehensive, coordinated child care program for employee and student families in a medical center community. The model child care system as conceptualized in this project provides: (1) a Counseling-Coordination Office for compiling community resource information and assistance-in-placement services, and (2) child care program services (In-Center Care, Family Home Care, and School-Age Child Care). The purpose of this child care system was to provide parents with ease in finding and making decisions about child-appropriate services and to increase stablization as a family unit to the extent that needs for dependency, accessibility, and specialized services were met. The system was designed to be responsive to the expressed needs of the 204 families who responded to the initial University of Colorado Medical Center survey pertaining to concerns in child care service delivery, and to nation-wide opinion about such concerns. The report discusses in detail the various components of the overall model: The Counseling-Coordination Office, the child care program model (the In-Center model, the Family Home Care model, the School-Age Child model), community involvement and information sharing, and the administrative framework. Goals and research plans for the second year of the project are listed. The 25 appendixes contain a sample collection of the forms, records, questionnaires, and surveys used during the first year of the demonstration project. (CS)

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COMPREHENSIVE, COORDINATED CHILD CARE PROGRAM FOR EMPLOYEE AND STUDENT FAMILIES IN A MEDICAL CENTER COMMUNITY

YEAR I PROGRESS REPORT

Jane E. Chapman, Ph.D., Project Director

September, 1973

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CHAPTER I: INTRODUCTION

How the Project Developed

A survey designed to ascertain parent needs in obtaining child care services was conducted on the University of Colorado Medical Center (UCMC) campus in metropolitan Denver between September, 1971, and January, 1972. The population polled for this purpose consisted of the 1,700 students and trainees and the 4,000 full- and part-time employees of the Medical Center.

Two hundred four families responding to the initial survey were followed over the above specified time period to determine what they perceived to be their critical needs in child care service delivery (see Table I below). Information was obtained via both questionnaires and personal interviews.

TABLE I

Ethnic Status of Survey Population as Compared to Ethnic Status of Medical Center Employee and Metro Denver Population

Ethnic Status	Survey Population	Medical Center Employees (10/31/71)	Denver Metropolitan Population (1970 Census)
White	60%	82.7%	85.9%
Spanish Surname	8%	7.5%	9.0%
Black	16%	7.9%	4.2%
Other Minorities	8%	1.9%	.9%
Unknown	3%	---	---

Concerns repeatedly highlighted in the resultant data led to the formation of a steering committee which was comprised of an interdisciplinary

professional and lay group of Medical Center employees and students headed by a project director.[1] The work of this group led to design of a proposed demonstration project for child care service delivery.

The Demonstration Child Care System

The model child care system as conceptualized in this Project provided: 1) a counseling-coordination office for both the banking of community resource information and assistance-in-placement services, and 2) child care program services (In-Center care, Family Home care and School-Age child care). Family Home care and School-Age programs were designed to be satellite to the over-all Center care program. Ideally this model system was to provide parents with ease in finding and making decisions about child-appropriate services and to increase stabilization as a family unit to the extent that needs for dependability, accessability and specialized services were met.

Design of this system (Figure 1) was considered to be responsive to consideration of both 1) expressed needs of the 204 families who responded to the initial UCMC survey pertaining to concerns in child care service delivery and 2) what is evident nation-wide about such concerns (at both levels, expressed needs were found to be strikingly consonant).

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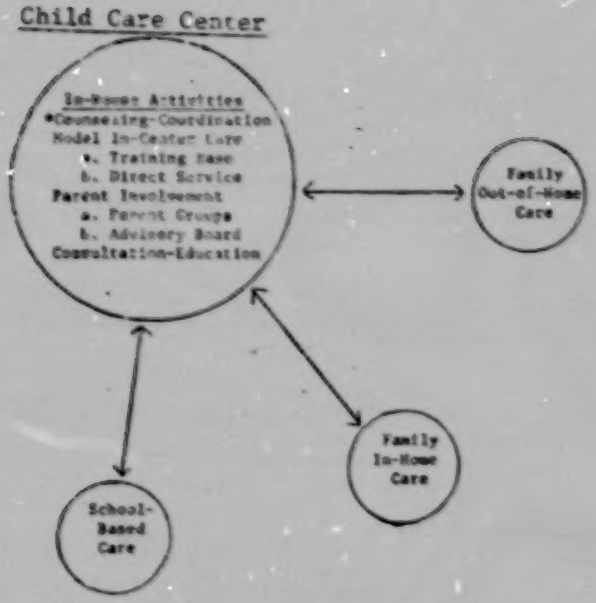
[1]From January, 1972, to the onset of Federal OCD funding on June 1, 1972, planning endeavors were supported by a $15,000 planning grant awarded the steering committee by the University of Colorado Medical Center Staff Advisory Council.

Figure 1. Comprehensive, Coordinated Child Care System



*In our industrial setting, this service is placed in the middle of the Medical Center where there is greater accessibility to employed and student consumers.

It was felt that such a Child Care system had to delineate and operationalize criteria of "coordinated" and "comprehensive" if it were to be an effective need-meeting resource for parents and their children. General definitions of "comprehensive" and "coordinated" were conceptualized and defined as follows:

Comprehensive - the existence of a broad array of resources, any one of which meets the perceived health, educational, emotional and social needs of the consumer (parent-child dyad.)

In actualizing the definition of "comprehensive" into systems model terms as applied to program development in child care, the Project envisioned a

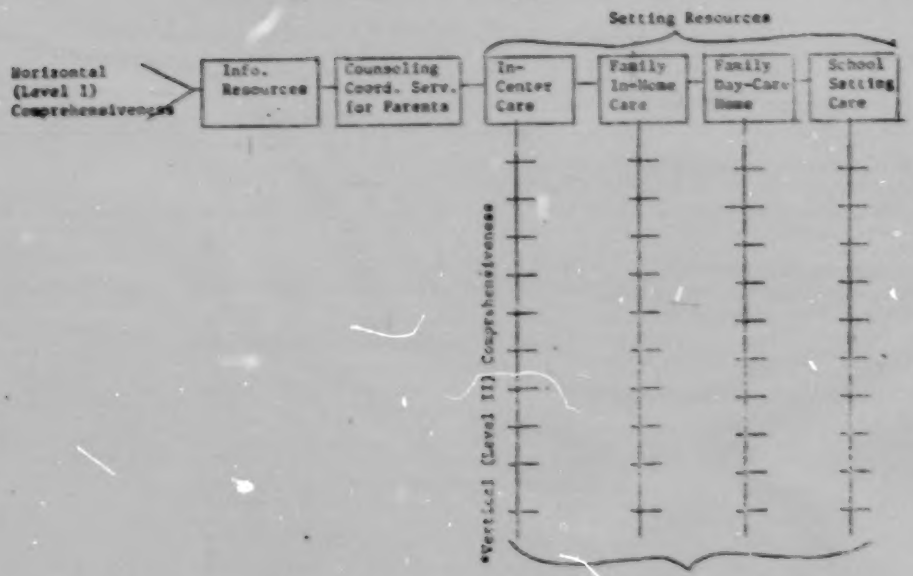
comprehensive systems model as consisting of two levels:

Level I - Variety of resources of child care settings from which parents might choose regardless of economic level.

Level II - Variety of quality program dimensions within each child care setting designed to meet individual child and family needs.

Evolving out of attempts to diagrammatically conceptualize both levels of comprehensiveness inherent in the model, the following pictorial representation has been developed:

Figure 2. What a Systematized Comprehensive Child Care Model Should Be Able to Provide



See Appendix I [illegible] Child Care Setting Quality Criteria

Coordinated - provides for planned interactions between two or more resources (persons or agencies) which are purposively designed to meet a commonly held goal. "Coordination" is the qualitative, active process which makes the comprehensive array of resources easily usable for consumers, i.e., accessible.

In actualizing this definition of "coordinated" into the Project model, a series of subsystems was conceptualized within the Child Care Project system that would essentially wire the comprehensive elements together in a maximally-usable general system. Data-gathering within each of these subsystems was planned to moritor coordination variables. Subsystems developed were:

1. Counseling-Coordination Service. This subsystem provides for initial entry into the child care system by consumers. Data obtained in this process involves information pertaining to: initial needs of consumers; follow-up of emerging needs and service utilization patterns of those families not using demonstration child care settings; availability of community child care resources.
2. Child Care Program Development Service. This subsystem is concerned with a model In-Center setting, Family Home Care settings and School-Age settings. Data obtained in each setting involves information pertaining to: emerging needs of model system consumers; needs of Project staff in delivery of quality service; feasibility issues in achieving quality criteria and coordination of special services; feasibility of training Child Care Workers for Family Home and School settings; cost analysis of quality care and coordination of a multiple-setting child care system; stability factors regarding children (developmental progress, attendance patterns.)
3. Advisory Board. This subsystem provides for input from parent representatives using the entire system as well as for UCMC professional representative input. Data obtained in this process involves information pertaining to: emerging needs and desires of model system consumers; initial feasibility issues in coordinating with Medical Center resources; Project staff's utiliration of a Board; response of consumers to cost analysis; influence of consumers in modifying program; influence of consumer pressure in obtaining existing financial resources within the local, regional and national area; organizational development variables.

Summary

The original proposal as submitted to the Office of Child Development in March, 1972, specified that the primary project goal was a demonstration of the development of a coordinated child care system committed to providing comprehensive services. Evaluation of whether such a model was needed locally or nationally was not involved as an issue - our own survey research and review of child care literature substantiated the press for service per se. However, it was felt that the process of actual model development and the data that might be derived therefrom constituted a potential body

of educative knowledge that would be useful in considering feasibility issues for others interested in attempting such endeavors.

A secondary purpose of the demonstration project emerged out of the recognition that such a model was an ideal system from which data might be obtained that would lend itself to exploratory research or that might eventually speak to specific research questions. For example, in spite of substantial survey data for the purposes of process planning, little is known about: parental attitudes and needs regarding child care setting; quality of programs and utilization patterns as one studies them over time; pre-placement evaluation of children and its relevance to placement of children in appropriate settings or children's stability in settings over time; whether it makes a difference if a setting has coordinated and comprehensive special services and which variables are most significant.

Even before the Project proposal was formally submitted, a substantial amount of data had been obtained with respect to the first stage of any new program development - planning. In part, the grant proposal itself reflected both the process and the evaluation of the progress made in the planning required to bring quality care and effective service delivery to bear on a significant social need. Efficacy of the planning phase as delineated in the Project proposal seemed highlighted in 1) the ability of the Project staff to get a complex model off the ground in eleven months, and 2) the extent to which Project staff were utilized in providing technical assistance relative to the community at large prior to funding and during the first project year.

Because the Project has been process-oriented rather than, for example, based on a defined goal-attainment design, data derived is largely experiential and often a result of trial and error. Enormous amounts of data have been collected about the step-by-step process in program implementation; some of it, due to its very nature, is impossible to relate except in highly qualitative, narrative form. This data, together with our own more formalized internal studies (as well as those from our Outside Evaluation Team),[1]

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[1]Outside evaluation of the Project was carried out by the Bureau of Education Research, Boulder, Colorado, under the direction of William L. Goodwin, Ph.D. and Gene V. Glass, Ph.D.

were used as internal feedback in revising daily procedures, altering our administrative structure, and sharpening our thinking with respect to generated research hypotheses.

In the area of the emerging delineation of questions which the Project now has the increased capacity to explore, we have found our exploratory data about parental needs, involvement and utilization patterns of considerable interest as they might relate to stability issues in child care placement and overall effects on child and family. At the conclusion of the first Project year, we feel that our presentation of data raises even more but better defined questions to be pursued and acknowledges that, at this point in time, we are approaching - yet lacking - in totally definitive answers to our original questions.

CHAPTER II: THE COUNSELING-COORDINATION OFFICE

In conceptualizing our demonstration model, we believe that parents should be able to find and have available a comprehensive, coordinated delivery system of child care with a minimal amount of time and effort. Ideally, parents in any community should be able to call one phone number in a central office to obtain information about a wide variety of child care. Placement assistance should also be available to best match child care resources with individualistic family needs. In our child care system, the Counseling-Coordination Office (CCO) was designed to perform these functions at the time of initial need.

EARLY PROCESS VARIABLES IN PROGRAM DEVELOPMENT

A premature service press from the Medical Center community who had heard about our June, 1972, funding placed us immediately in the situation of having many people call our temporary project office before our informational survey of community child care resources was planned, returned, tabulated and banked. We very quickly came to realize that in setting up a comprehensive, coordinated delivery system, this information bank of what is broadly available is critical to everything else. Our reality was that we formally opened our Counseling-Coordination Office in September, 1972, with a limited data base from preliminary survey returns. As a re-survey was required before our data was to be completely tabulated and organized in a maximally usuable fashion, it was December; yet, approximately 175 consumer parents had utilized the CCO for assistance during those three months. We had opened a Pandora's box before we were appropriately ready.

A further factor influencing the CCO's initial function was the reality of the demonstration model In-Center program developing simultaneously. In Project pre-planning, it was felt that having at least one model child care setting established concordant to the opening of the CCO would provide the beginnings of a comparison population within the group of consumers who used the demonstration counseling-coordination services (e.g., consumers using

community settings "out there" and consumers using settings from the model child care system).[1] What was not anticipated was that, while there was a service press for placements, most of the parents wanted UCMC model services and, to the extent that parents requesting this placement had age eligible children (ages two and one-half to six years) or were willing to be placed on a waiting list, these consumers were pursued with much energy. The skewed focus and pursuit of this particular group stemmed from not only the wants of the majority of the consumers but also from the real financial need for filling the In-Center Program which had a considerable generative responsibility in cost-sharing. These factors, together with an inadequate data bank of community resources into which "other" consumers could be efficiently placed with the pace that the consumer demanded, contributed to the consumer viewed as eligible for the demonstration model setting tending to become the most attended and the most thoroughly studied after their initial placement.

Our hindsight view tells us that our total Project was very complex and at times unwieldy; a meaningful demonstration project could have been concerned solely with: 1) developing comprehensive community informational services, and 2) documenting parent needs and utilization patterns based on phone and face-to-face placement-assistance processes.

EXPERIENCE WITHIN THE CCO

General Description of our Consumers

Our demonstration population consisted of those persons requiring child care within the 1,700 students and the 4,000 full- and part-time employees of the Medical Center. From September, 1972, through May, 1973, a total of 517 new contacts were made at the CCO. Ten percent (10%) of our contacts came from students and 53% from employees; the remaining 37% of contacts came from the spouses of eligible students or employees. Of this latter group, 93% were wives calling for child care when the husband was the eligible student

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[1] Internal staff resources and budget plan called for the Family Home satellite settings to begin January, 1973, and School-Age Child settings to begin June, 1973.

or employee. Across all groups, 88% of the initial contacts were made by the mother.

Ethnic data (Table II) about our consumers shows a very close congruence between specific groupings of both the CCO consumers and the total eligible population at the Medical Center suggesting the CCO publicity and process has been such that no one ethnic group is more likely to use its services.

TABLE II

Ethnicity of Parent Consumers at the CCO Compared to the Total Medical Center Population

	UCMC Parent Consumers (n=417 of known ethnicity)	Medical Center (4/24/73) (n=3,433 of known ethnicity)
Anglo	80.6%	81.56%
Afro-American	9.6%	8.74%
Chicano	6.5%	7.43%
Oriental	2.6%	1.78%
American Indian	.7%	.49%
	Total: 100.0%	Total: 100.00%

In addition, the University Minority Affairs Office[1] indicates that 9.5 to 10.0% of the students at the Medical Center have been minority students during the '72-'73 academic year; our May, 1973, data indicates that 9% of our student consumers of known ethnicity were of a minority grouping.

Of all the parents contacting the CCO prior to the interview appointment, 78% wanted the UCMC demonstration model child care services for their children; this was despite well-advertised statements of the mission of the

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[1]Personal communication of May 4, 1973.

CCO to share information with parents on all known child care placements in the Denver area. Of the parents who were "planning ahead" and could place their children on a waiting list, 90% expected to utilize the demonstration model services. In our eagerness to fill our model service settings, we failed to formalize responses of parents as to why "us" in contrast to settings "out there". Informal comments seemed to support an accessibility-to-work issue and the implication that, if it was a federally-funded and Medical Center service, it automatically had to be "better".

Procedure for the Consumer Using the CCO

In setting up a counseling-coordination procedure, we wanted to create a usable, humanistic process for the consumer which would also allow us to collect information about parental desires and needs of their children. Beyond our project planning survey data, which indicated strong parental need for information about resources located in a central place, none of us were certain about what constituted an "assistance process". Further, we were reluctant to tightly preconceive a professionalized structure that would foster a demand characteristic phenomena within which we would lose the "naturalistic style" of parents.

As to the kind of information we needed from parents in both initial and subsequent contacts during placement, we were also initially uncertain. Hypothetically, we derived a lot of idealistic "shoulds" from our combined knowledge of child development but we realistically did not know what the critical variables would be in determining a satisfactory placement and whose judgment of "satisfaction" would ultimately be most critical. We were keenly aware that parental satisfaction with a setting for their child might be different than ours; therefore, we decided to take a more passive stance with respect to what the parents said they wanted and to let more defined, intrusive procedures evolve when we experienced parents who acknowledged frank confusion or marked ambivalence.

Beyond placement per se, the Project also was committed to demonstrating the need for and utilization of specialized services within a "comprehensive" child care system relative to social, emotional and physical health aspects of family living. We were particularly ambivalent if we wanted to take a probing interview approach with parents if, in view of their being informed

of the availability of such concern and services, they chose not to spontaneously bring family "problems" to the fore. Our needs for structure to the contrary, we decided to take an exploratory approach, developing forms on which we could capture spontaneous data beyond the usual identifying information.

Eighty-eight percent (88%) of the consumers in the first year initiated their contacts with the CCO via the phone; an additional 10% first sought us out by "dropping in". Other contacts were initiated by letter, sometimes from out-of-state by prospective employees or students. To capture the initial, spontaneous needs and desires of these parents we developed our Initial Contact Form (ICF). Following a brief telephone interview, a face-to-face interview was scheduled at the CCO (or at the employee's work site on campus) to explore and tabulate needs in more depth. Because of variable working schedules of employees and students, it seemed important to schedule interviews at irregular hours which best fit with the possibility of the presence of both parents.

After the face-to-face interview with the parent(s), we shared information about what child care arrangements were available. This information throughout the year has been a "to the best of our knowledge" kind of operation and this has not always been satisfying to parents. When parents wished the services of the Project's demonstration model services from the onset, it was relatively easy to answer their questions about quality issues and to instantly arrange for them to visit the demonstration model Child Care Center. When parents wished services from the model Child Care Center which were not yet developed, a waiting list developed and we assisted them in finding temporary settings in the general community until their child became age eligible for our In-Center Program or until our Family Home Care and School-Age Program became viable. To this "waiting" group and the group which wanted something other than demonstration model child care services, we gave parents as much information as we had and encouraged direct visitations of settings before they made their choice.

At the end of the first Project year, follow-up evaluation of the consumer group who used community settings indicated that they were generally not as pleased with the assistance process as was the group using the demonstration

model services. We attribute their less positive commentary to two factors: 1) the paucity of information we often had to fit with their specific family needs and 2) the lack of contact with this group over time (as either due to our failure to initiate follow-up in finding out if they were satisfied or needed more help or to consumer failure to recontact us for further assistance.)

During the first year, the CCO also literally "did more" with the children of the parents seeking and finding an appropriate arrangement with the demonstration model child care settings. If a child was going to enroll in our model Center, the CCO did a comprehensive developmental evaluation of these children and developed a detailed, but easily usable, health history and examination format for the parents and physician (Appendix II). These materials accompanied a child when he or she was enrolled in any of the model Child Care Center programs. The increased child focus with this particular group of consumers, we feel, also contributed to a parental feeling of having been "more assisted".

Appraisal of our CCO procedure at the end of the year strongly suggested that we give <u>all</u> of our consumers equal treatment and that we develop a formalized follow-up "satisfaction" procedure for all of our consumers regardless of where their child was placed. Our data as to re-contacting patterns of parents clearly showed that, unless we initiated follow-up as to how they were doing with our preliminary help (information only), we were missing crucial data in realistically understanding a complete placement assistance process.

<u>Parental Knowledge and Sophistication Regarding Child Care Issues</u>

Of particular interest to Project staff was the knowledge base about child care which parents initially brought into the seeking-of-service process. Specifically, we documented parental questions and concerns in two broad areas: 1) informational or structural questions and 2) program or quality questions. Examples of the former involved parental inquiries about days, hours, ages of children, fees for different settings. Examples of the latter included parental questions about program philosophy and content, nutrition, staff ratio.

Seventy-five percent (75%) of consumers at the time of initial contact did not raise quality issues but, of the 25% who did, 1.4 quality concerns per person were articulated. The single most frequently mentioned concern (43%) was about educational aspects of a program ("pre-school"). A further concern, minimally mentioned, was around staff issues (staff ratios, staff training, etc.) Male consumers were nearly mute with regard to verbalizing quality issues (.15 quality concern/male parent). Parents were more able to articulate structural concerns at initial contact, e.g., type of setting, ages of children taken, fees, days and hours open (in that order).

Being interested about when or if parents eventually do raise more quality concerns in the preliminary placement process, the CCO face-to-face interviews (scheduled subsequent to initial contact) were analyzed. Content analysis of "sit-down" interviews up to December, 1972, showed that less than 5% of the interviewees spontaneously verbalized quality concerns. We also followed parents' verbalizations once they visited our model In-Center Program. During and immediately after visitation of the model center, 43 of 55 parents (70.22%) were able to verbalize one or more quality issues. Again, the single most frequently mentioned concern was about educational programming with the secondary issue being about "staff".

The "why" underlying parental ability to raise more quality concerns in general after visitation may speculatively be that experiencing the physical realities of a child care setting "flush out" a parent's child care construct so that they can more effectively verbalize. Our In-Center staff was sensitized to capturing spontaneously-raised questions and concerns; yet, the more social informality of "showing" someone a milieu may be the very impetus to allay fears of "coming up dumb" by asking.

That the majority of parents emphasized educational, "pre-school" programming did not exactly surprise us as our pre-Project planning survey showed that 81% of parents desired this as a part of desirable child care. However we felt that, given the opportunity to express themselves more freely (as within the context of a CCO interview), other more humanistic concerns would be expressed, e.g., the "kind" of person who would be care giving, finding out how certain critical events in a child's day would be managed, etc. Whether

such variables are truly critical to satisfactory placement for a child is at present only an internal bias of the Project staff and these are not convincingly verifiable by hard data obtained this exploratory year.

It may be hypothesized that the education emphasis reflects an overpervasive value of parents with respect to the only environmental influence they consider "best" for their child. Without further examination, one might be left with a feeling that parents were concerned only with cognitive "academics" at a time in a child's life when other experiences (e.g., interpersonal learning with peers and meaningful adults, exploring the world through play, etc.) are as critical. It may be that parents do appreciate that "pre-school" can have a broader meaning than letters, numbers, colors and rote-learning; they may assume that if a setting has taken the trouble to include "pre-school programming", the care-takers can be trusted to be likewise concerned with the social-emotional aspects of development. Perhaps such emphasis also reflects a broader expectation of parents that primary and secondary educational systems take increasing responsibility for the total child - a trend we have seen emerge in recent years, albeit controversial. Whereas many parents have seemed willing to entrust and expect the school system to provide an experiential world for children beyond that of "academics" when the child is enrolled in elementary school, the same implied expectation may now be occurring when parents decide to allow another care-taking system to be a part of their child's life.

Research-wise, we are not prepared to speak to whether lack of an articulated concern about quality issues that we may feel parents "should" ask means no concern at all within the parental value system; nor, are we prepared to convincingly state which qualitative variables contribute to the most satisfactory placement whether defined by Project staff or parents. But, we do have some hunches stemming from follow-up over the year of In-Center Program parents which suggests that parents will become concerned with other quality issues particularly when they are sought out (Chapter III).

A notable characteristic of our "parent" data is that it is primarily obtained from the mother (e.g., 88% of our initial contacts were made by the mother and rarely did both parents attend the face-to-face interviews even when convenient hours for both parents were arranged.) That the major onus

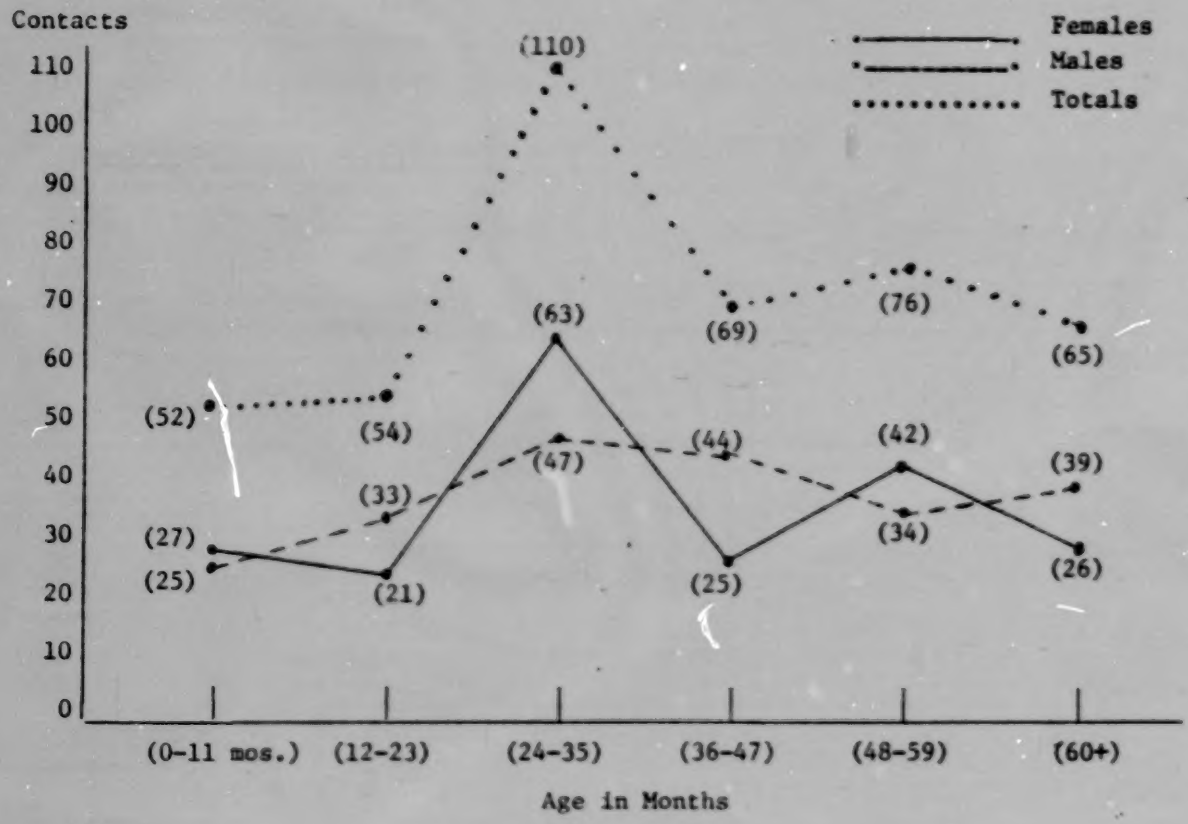
for exploring and delineating child care needs remains the mother's seems significant since we feel that we took a very active posture through both written publicity and initial phone contacts to indicate that child care is the concern of both parents. Accordingly, we feel much is to be learned about father attitudes, expectations and satisfaction.

That our consumer population may have more "faith" in a Medical Center program is not to be overlooked. Coupled with federal funding from a well-known child-oriented agency, we may have a phenomena of assumption of quality which may not have held up if these same parents had been investigating general community resources. Because we do not "know" this at this point, all the more reason for our recommendation to ourselves that we 1) utilize more structured, intrusive procedures for both helping and finding out in more depth what both parents want and need at the level of the information-seeking and placement process and 2) concentrate on follow-up of CCO consumers using general community resources with the same vigor as follow-up of our demonstration Child Care Program services.

Characteristics of Children for Whom Care Was Sought

The age grouping of 24-35 months indicated the greatest need for child care of all types, as Figure 3 indicates.

Figure 3. Age and Sex of Children for Whom UCMC Parents Sought Child Care Services at the CCO, September, 1972-May, 1973



The higher incidence of children for whom services were requested between 24-35 months suggests a general "cultural readiness" age for parents to separate from their child and to accept surrogate care. However, further breakdown by sex within this age span is notable if one looks at the data within six-month increments, e.g.:

Age in Months	Male	Female
24-29	16	30
30-35	31	33
	47	63

The significant difference in the incidence between sexes at the 24-29 month point stimulates thinking that parents may be earlier differentiating readiness on a sex basis for girls with a readiness age for boys perceived by the peaking in the 36-47 months age span (44 males versus 25 girls).

While developmental evidence suggests that girls are somewhat more advanced in these early pre-school years, we ponder if mothers - the major pursuers of child care - have specific and/or intuitive criteria that they utilize in deciding sex-differentiated readiness. From our standpoint, we were impressed in the placement process with the two and one-half year development of many of the two year olds for whom Center care was requested. Our frustration in meeting parental desires at this juncture was in adhering to the Colorado law requiring a chronological age of two and one-half before legal entry into Center care.

We are pursuing the feasability of the law accepting a developmental rather than a chronological age. Discussions with the State Department of Social Services concern a plan by which we might determine a child's level of functioning by developmental assessment and, should it suggest a child comparable to an age of two and one-half, the child would be enrolled in the In-Center Program for more concentrated follow-up (e.g., re-test measures, staff observation indicators, stability of attendance, parental satisfaction).

Utilization and Placement Experience

Table III documents the overall utilization pattern of the CCO for the first nine months of the Project. This Table suggests a somewhat "steady state" of about fifty new contacts each month. The peaks in September and May (93 and 78 contacts respectively) are attributable to an "opening phenomenon" (September) and increased contacts (May) seemed attributable to occurring just prior to the opening of the UCMC School-Age Child summer day camp. Deleting September and May contacts leaves an average of 49.43 new child care concerns per month.

TABLE III

Frequency of New Contacts at the CCO by Month of First Project Year

Month	New Contacts	% of Total
September	93	17.99
October	53	10.25
November	50	9.67
December	46	8.90
January	59	11.41
February	50	9.67
March	43	8.32
April	45	8.70
May	78	15.09
Totals	517	100.00%

The majority of parents (58%) wanted care five days per week as aligned with parents' work schedules. Of this group, 81% wanted full-day care each of the five days. Only 45% of those parents who did not need five-days-per-week child care required full-day care. This pattern suggests that, if child care providers wish to decrease the chances of caring for children during irregular hours, they should opt for care for five-day-per-week children.

Of the 517 contacts made to the CCO involving requests for information about child care during the first eight months of operation, 152 actual placements were made. Placements were defined as following parents through until we knew that a decision and enrollment had been made in a child care setting. The following Table depicts the utilization patterns of our two groups of consumers: Group A utilizing any of the existing demonstration model services, and Group B utilizing resources in the general community.

TABLE IV

Placement of Children of Families Utilizing the CCO

Group	Type of Setting	Number
A	In-Center Care	75
	Family Home Care	1
	In-Home	(0)
	Out-Home	(1)
	School-Age Program	9
		85
B	In-Center Care	4
	Family Home Care	58
	In-Home	(10)
	Out-Home	(48)
	School-Age Program	5
		67
Total		152

If the parents wanted immediate care for their child and a demonstration model setting was available, they were placed 100% of the time by us; if a setting of the parents' choice was not available for them within model services and they required a search in the community, we were able to place them immediately only 80% of the time. The major factor here was our spotty knowledge of what was actually available coupled with what we knew was not available for those parents where accessibility to the Medical Center was a critically decisive factor. For example, 65% of our parent consumers resided in the East Denver area and the resources for infants and toddlers (age two years and under) were meagre in contrast to a critical expressed need for care of this age group by our parents. The following Table expresses what we were up against even when we "knew":

TABLE V

Minimum Age Accepted in Child Care Settings
in Denver County and East Denver Subsection, February, 1973

Age	Child Care Centers				Family Home Care Facilities			
	All Denver	%	East Denver	%	All Denver	%	East Denver	%
0 - Infants	---	-	---	-	383	71.7	39	64.0
2 wks. - 1 yr.	9	4.5	1	2.6	48	9.1	4	6.6
15, 18 mo. - 2 yr.	8	4.0	0	0	74	13.9	13	21.3
2 1/2 - 3 1/2 yrs.	178	89.5	38	97.5	24	4.5	4	6.6
4 - 5 yrs.	4	2.0	0	0	3	.6	1	1.6
7 - 9 yrs.	0	0	0	0	2	.4	0	0
TOTALS	199	100.0	39	100.1	534	100.1	61	100.1

As can be seen, only <u>one</u> center accepting ages two and under was located in the six target zip code areas which surround the Medical Center and, while there were fifty-six family care homes in this area, these settings are limited to only two children in this age bracket. While 102 of our calls pertained to inquiries about care for the two and under child, (and requests were primarily for family home care), our existing community resource of only 112 spaces (variably available) in an <u>accessible</u> location for consumers posed great difficulties.

<u>DEVELOPING INFORMATIONAL RESOURCES</u>

In the first year of the Project, we have found that the viability of a counseling-coordination office hinges on <u>being able to obtain</u> certain critical data:

1. Existence of resources at any given point in time.
2. Kind and number of settings.
3. Basic parameters of each setting, e.g., what is offered, where located, cost, hours.
4. Vacancies within settings.
5. Parent expectations and needs compared with setting characteristics and vacancies.

However, developing such an information bank about resources has been found to be a slow step-by-step process. We have learned:

1. Considerable lead time should be allowed to obtain an adequate information base before opening a Counseling-Coordination Office lest parents be as frustrated with some information as with no information.
2. It is often difficult to obtain information due to the sensitivity of individual care-givers and regulatory agencies.

At the time this Project was written in 1971-1972, the metro-Denver (five county) area had no centralized listing of child care resources available to the general public. Information could be obtained via the Yellow Pages, local newspapers and supermarket bulletin boards. Name and address listings of licensed homes and centers were available through county welfare offices and/or the State Department of Social Services - the agencies charged with licensure. The availability of these lists, however, was not advertised, and public access was thereby limited by having to ferret out where in the bureaucratic structure such information could be found.

Determining the Information Needed

In addition to identifying fundamental information about a listing of child care resources (e.g., type of setting, location, etc.), we felt that ideally some knowledge about all of the recommended qualitative characteristics of milieux for children would be important for each setting if we were to anticipate an adequate informational base upon which to assist parents in selecting the most appropriate child care setting. At minimum, we felt we should have quality information about those items which are included in the licensure regulations for the state of Colorado.

Therefore, in the planning phase of the Project, a list of forty-six child care setting characteristics which we refer to as our Quality Care Criteria were developed (Appendix I). These criteria are characteristics of child care settings that were rated as important to family convenience and safe, growth enhancing care for children as obtained from: 1) parental responses to our planning survey, 2) expertise from child development professionals on the Project's steering committee and staff, and 3) recommendations made in child development literature regarding child care settings.

Because the Project proposal also called for an availability of In-Home Services (a child care worker coming into a family's home), we knew we would have to recruit, interview and make such "private practitioners" available to parents with some reasonable assurance that they were adequate to be considered as child care workers. While characteristics of the ideal child care worker are illusive to formalize, we felt that such persons should be able to appreciate and carry out the criteria listed in Item #8 (a-j) of the Quality Care Criteria.

Trying to Get the Information Needed

Calls for in-home care were infinitesimal in contrast for calls for out-of-home care and, thus, gathering of such an information bank was given secondary priority. Our approach was to use an advertising and screening procedure; publicity around the Medical Center and in local newspapers resulted in twenty-one women contacting us for interviews resulting in an information bank of seven.[1]

In obtaining information about child care settings "out there", gaining access to it posed a series of problems. One conceivable source was the fairly detailed data that had already been obtained and banked through the licensure/consultation process of the State Department of Social Services. However, this was not available to us as it is considered confidential information.

Gaining information from each licensed setting directly posed even further problems. Even though we could obtain some of the licensed listings (names and addresses) from most county divisions of Social Services, there were those county agencies who were uncertain or reluctant about releasing even this basic information. Yet we felt that full support of the licensing authorities would be most crucial in obtaining the cooperation of the center operators and Family Day Care mothers. For example, during the planning of the demonstration Project, a small task force visited a number of day care centers just to obtain some programmatic ideas and to talk with operators about what parents

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[1] Transportation was a major difficulty with this group as fifteen out of twenty-one did not have their own cars.

seemed to want. Feedback from several operators suggested a high degree of sensitivity about people "checking on them." It seemed common sense, therefore, to incorporate the State Department of Social Services and local county governing bodies in any kind of information-gathering process that we planned.

Fortuitiously, the Denver Mile High Child Care Association (MHCCA) was, at the same time as our grant award, trying to spearhead a drive to set up a centralized referral service. In their preliminary phase (funded under a small OCD grant), they had been able to gain the cooperation of the United Fund Agency to assist in planning and to "maybe" provide some financial support. Because of our demonstration needs and the realistic community service needs which the Mile High Association perceived, we joined forces in strategizing how resources could be pooled and overlap of effort and information avoided. We envisioned an eventual telephone referral service for metro-Denver, located within the Mile High Association, with our demonstration model utilizing the same referral service data for purposes of our demonstration project population.

Strategy meetings were held with staff of our Project, Mile High Child Care Association, State and local 4-C organizations, regional Office of Child Development, United Way, State Department of Social Services, Day Care Mothers Association and representatives of the five county department of Social Services. Three issues were prominent in these meetings:

1. The most effective way to get the information: A mailing survey seemed to be the most cost-effective way. (The manpower which would have been needed to visit each of the approximately 400 centers and 800 Family Day Care homes in the metro-Denver area made this approach not feasible.)

2. The psychological effects of the kinds of questions and sponsorship of the survey: Considerable sensitivity existed as to what and how to ask questions without offending. It appeared that many of the group felt that some of the licensed facilities were so meager that even being asked questions about some quality dimensions would set up a resistance expressed in not providing any information at all. The knowledge that there was a not-so-small group in the community that was attempting to get present State regulations reduced gave some credence to this concern. Sponsorship of the survey by the demonstration Project alone was unanimously agreed upon as destining a very poor response for two reasons: first, Medical Center auspices does not carry as much weight locally as it does nationally, and second, resistance to a "research" orientation might be greater, or at least interactive, with the above-mentioned concern. Additionally, it was felt that development of an information bank was a broad community concern and we might as well start presenting a coordinated sponsorship approach.

3. Who was going to pay for what aspect of the survey, the tabulation, and banking of the information in usable form: No one representative group had all of the time, money and equipment that development of a central information bank would entail. Considerable time was taken in deciding who would and could do various aspects of the task. Costs for secretarial service, duplication and mailing of the surveys was borne by the demonstration Project as this was budgeted into our grant award.

Developing the Setting Survey Form

Several rough drafts of a survey questionnaire were developed by Project staff together with an administrative assistant of the Mile High Child Care Association. These drafts were based on an information base that we as Project staff felt we would like to have in our demonstration and copies were submitted to the group at large in order that concerns and suggestions be raised. We felt the final version to be less than ideal in terms of inclusion of informational items we had hoped for. Because of the differences in characteristics of the Day Care Center community and the Family Day Care mother community, somewhat different questionnaires were developed (Appendix III).

Results of the Survey

Approximately 1,100 licensed child care centers and family home care mothers in a five county area were contacted in early September, 1972. Their names and addresses were obtained from the most current list of licensed child care providers made available to us by the licensing agencies. Twenty-five percent (25%) of those initially contacted responded. A survey follow-up was conducted wherein a second cover letter was used. This cover letter was much more direct with increased emphasis on the utility of a child care referral system to the child care provider. The result was a jump up to a final 64% return rate.

Our decision to bear the expense and re-survey the same population was fortuitous as our initial hypothesis was that we had indeed countered marked resistance to what we considered as meagre but necessary attempts to test the "openness" of child care settings to evaluation. Random calls by the CCO to non-respondents suggested additional hypotheses and strengthened our decision to try again - i.e., 1) some child care givers had been on vacation or had

been short staffed during early September; 2) some settings were then experiencing a fall rush and were "too busy"; 3) some respondents indicated indirectly they did not know what was "in it for them" to respond. We feel that our increase in response was probably due to three interactive factors: 1) a new cover letter appealed to those who had not previously appreciated the value to them to be listed and referred to; 2) fall rush was somewhat stabilized by the time the second survey was received; and 3) a second survey request or reminder seems to generate increased attention in a survey population.

Practical structural information (e.g., cost factors, hours open) was much more completely reported by respondents than quality criteria information (e.g., a written program of planned activities). While we were able to use the survey information to begin to differentiate settings qualitatively, our limitations on questions asked and the frequent poverty of responses to certain questions led us to an early realization of the necessity of plans for obtaining more complete and reliable information.

Items in the survey which are related to our rating on quality are tabulated in Table VI. The percentages quoted reflect only the number of respondents to the surveys who satisfied <u>minimal</u> standards for that particular criteria.

TABLE VI

Percentages of Survey Respondents Meeting Eight Different Criteria for Quality In-Center and Family Home Care Settings

Rating Criteria	Child Care Center		Family Home Care	
	Number	% Meeting Criterion	Number	% Meeting Criterion
Parent Involvement[1]	87	88.8	0	0
Specific Program Existant	85	86.7	374	79.0
Absence Policy	83	84.7	263	55.6
Developmental Assessment[1]	70	71.4	0	0
Illness Policy	55	56.1	267	56.5
Consultation for Problems	37	37.7	5	1.0
Referral to Special Services	15	15.3	0	0
Rest Policy	6	6.1	20	4.4

[1]Not included in FHC survey.

Analysis of responses on the survey showed understandably higher response rates in those categories which reflected items required in the Colorado licensure regulations for child care centers, e.g.:

1. A definite procedure for replacing a child care worker in case of illness.
2. A written program of activities for children.
3. A written procedure to be followed in case a child becomes ill (including a set-up isolation room).
4. Regular parent conferences.
5. Written policies concerning gathering of medical, social and developmental information.

However, it is interesting to note that even for these items required by law, the percentages are not 100%; e.g., with respect to handling an illness in a

child, only 56.0% met this criterion in spite of the requirement to have an isolation room where the child can be monitored in case of illness. While the rate of occurance was higher for regular parent conferences (88.8%) and for a regular method of child assessment (71.4%) in child care centers, a considerable number of children are not receiving services felt to be at least minimal by law. That regulations do assist, however, seems reflected in the significantly lower rates of occurances of those services not required by law, e.g., consultation about problems of children available in only 37.7% of centers and a referral policy for children demonstrating special needs available in only 15.3%.

While our comparison data is not comprehensive, we felt the discrepancy rates of occurance between child care centers and family day care homes was notable. In spite of the "isolation" of family day care mothers, it appears that when it come to a program of planned activities for children, they don't do "all that poorly" comparatively (79% versus 86.7% for centers). However, the well-known problem of replacing oneself when there is illness of the family day care mother is again reflected (55.6% of family day care homes having a policy versus 84.7% for centers). Dramatically low is the rate of occurance of regular consultation available (1%) and a referral policy for children with special needs (0%).

The above data, while not at all as complete as we would have liked for basic informational and placement purposes, did support us in pursuing some very early general project directions and realistically facing what some of the feasibility issues were going to be in developing a sound counseling-coordination service. For example, we felt supported about our notion of a comprehensive model of child care with the satellite system of family homes when we looked at the discrepancy between consultation and referral services for special problems in contrasting centers and family home care settings. Further, around just this issue alone, we became aware that if we were placing a child who had special problems from the onset (or a child who had some immaturity of function which might require closer observation over time) and parents decided on family home care, our CCO would have to carefully ascertain if such a setting had the capacity for close observation, consultation and/or referral services. If a setting did not have these capacities, but was an appropriate

setting otherwise, then perhaps an appropriate function of a counseling-coordination office would be to periodically check with parents and care-giver as to the progress of the child.

A fundamental gap in the survey data is what Abt Associates[1] found to be the most critical variable in a child care center, i.e., the quality and quantity of warm, dedicated and intelligent care-givers who interact on a daily basis with children. We were unsuccessful in our attempts to add questions to tap this dimension on the community-sponsored survey because of the presumed "threat" this would pose to operators. Our response to this gap in knowledge has been incorporated into our plans for the second year of the Project in terms of projecting to do on-site visiting of settings in which we have already placed children or which are located in our general north-east Denver area (and which, therefore, have a higher probability of being used by us as a placement). We plan to study and relate the approaches which we have found to be met with the least threat and resistance. Through this pilot approach, we hope to discriminate more clearly if the "threat" as articulated and interpreted by licensing groups is truly a reflection of the nature of child care setting operators or if, in part, the threat is a reflection of the frustration of the licensing agencies in not having the resources to provide the supportive/evaluation consultation to existing settings that they know is needed.

Planning for Putting the Obtained Information in Usable Form

Since the eventual goal for use of survey data is to be able to direct parents who call in or stop into a central office to resources based on their expressed needs, it is necessary to have as much data on each setting organized in a way that it can be scanned quickly and can be simply categorized according to broad need indices expressed. For example, from our very premature experience with parents calling into the Counseling-Coordination Office before the information bank was developed, we knew that two critical criteria for selecting a setting were geographical location and family home care versus day care center settings.

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[1]Abt Associates, A Study in Child Care, Cambridge, 1971, as quoted in Infant Care Abstracts of the Literature, by Tannis M. Williams, Consortium on Early Childbearing and Childrearing, Washington, D.C., 1972.

It was determined that a Kardex system would be our most effective banking approach under given budgetary constraints. Following are the procedures that were utilized:

1. A Kardex card was divided into categories for information which directly reflected the questions asked in the survey. Everything that became known about a setting could be entered.
2. All cards from a given zip code were grouped in visual slide trays.
3. Cards within zip codes were differentially colored to delineate day care centers from family home care settings.

A copy of the Kardex card utilized is found in Appendix IV.

Planning for Keeping Obtained Information Current

Getting through the extensive process involved in obtaining initial information was experienced by us as being half the battle. A further planning strategy that we feel must be initially planned for is keeping data current, e.g., 1) monitoring changes in the basic characteristics of settings, such as available vacancies or whether they are still in business or not, 2) surveying settings newly in the business, 3) obtaining feedback from parents as to their reactions to particular settings, 4) finding a way to obtain information on those settings which have consistently resisted responding to the questionnaire.

Because of financial constraints, we felt that all of the above problems could not be taken on at once. The following procedure was developed for this first year of operation:

1. Each month, on a rotating basis, each setting which provided a response to the questionnaire and was listed in the Kardex system, would be called by a secretary for "updating." This would consist of finding out if a) the setting was still in business, b) how many vacancies were available, and c) if there were any substantial change in the characteristics of the setting.
2. New listings of licensed facilities from the Department of Social Services would indicate settings which did not exist at the time of the original survey. An identical questionnaire (and repeat mailing, if necessary) would be sent to the new care-giver and responses added to the information bank.

As parents have spontaneously reported back enhancing or contradicting information about settings used by the CCO, this has been noted. In our second year, we are systematizing UCMC parental feedback by both formally

requesting their feedback and contacting them routinely if we do not hear from them.

Obtaining information from non-respondents to questionnaires (in the case of our survey - i.e., some 36% of all community settings) becomes critical if one is to have a truly comprehensive data bank. While we have the Project staff capacity to work on methods to obtain this information in the north-east section of the Denver area where our major demonstration thrust exists, anyone setting up a metro-wide or regional information bank must have strategies for finding out about the "invisibles". If nothing else, further exploration of repeated non-respondents might lend understanding to the difficulty that seems to persist with both listings and full knowledge of quality being denied to the public for appraisal.

Lest one attach too much significance to the information one does obtain, we do feel that, ideally, information returned on questionnaires should be validated by personal visiting. Hopefully, an "open records" system can eventually be developed with licensing departments for cross-evaluating some qualitative criteria already obtained by information from their personal visits.

Conclusions

As we have gained an increasing appreciation for parental and child needs when a family seeks surrogate-supplemental care for their children, we gained significant insight into the value of our initial contact process for parents. Our own frustration in developing adequate informational resources so that we could be helpful (i.e., developing a placement process that is knowledgeable, efficient and satisfactory to parents) has strengthened our pressure on local coordinating bodies and legislative committees for critical changes in policies. At least in our local area, we now know where the holes are in actual existance of resources and what kinds of information we think should be available to "validly" give parents and placement-helpers a ready handle on settings so that a decision can be made. Through what seems to be a "simple" procedure - i.e., setting up a data bank of resources - you quickly learn what your local needs are.

We have reiterated that having a comprehensive-as-possible resource bank prior to opening a CCO is critical. Further, we stress that a solid, built-in follow-up system is highly important in determining whether or not parents actually are able to find what they needed or if one's assistance makes any difference to them. We have found that parents do not recontact us after either failure or success in finding a satisfactory setting. This feedback is critical for reasons beyond just knowing whether one "helped" or not; when parents visit a setting, making observations and judgments, this is valuable data which, if known by a CCO, helps determine which parents are idiosyncratic in their response to a specific setting. Thus more is known about the parent or, one can over time, determine if a setting is consistently responded to as good or mediocre and for what kinds of reasons.

We have found that a CCO can be a very cost-effective operation in servicing a large child care need after an initial resource bank is obtained. In our case, we had to start from ground-zero in obtaining information. Time in developing survey questionnaires, mailing, tabulating, and translating data into meaningful form is initially expensive and required conjoint community efforts in bolstering our CCO subsystem staff of three (full-time secretary, full-time counselor, and part-time assistance from the CCO Director who was also responsible for establishing evaluation systems for the entire demonstration model). In an industrial complex of our size, we feel that one could utilize the resources of a Personnel Department in gathering necessary community resource information, following which a full-time secretary and two full-time counselors could adequately: provide placement assistance, manage needs pertinent to updating of resources, and handle simple follow-up of consumers.

Ideally, we would like to see State licensing bodies and 4-C groups join forces in obtaining legislation and systems that would permit full informational resources being available; such a move would ultimately make the existance and effectiveness of a counseling-coordination office network a more feasible first-step in meeting critical child care needs.

How complex a counseling-coordination process needs to be (beyond informational resources and simple follow-up), is something we are just beginning to get a feel for. From the follow-up data we have in tracking our families

over passage of time in our model In-Center Program, we have seen needs emerge and we are coming to learn how we might enhance a counseling-coordination process from the onset which conceivably would hasten early detection of children needing better health supervision or who might subsequently show instability in child care settings. Until a more definite determination is made of how comprehensive it appears one must be at the outset of the placement process to ensure a stable, growth-enhancing experience for a child, numbers and characteristics of staff as well as kinds of procedures which are needed remains uncertain. To answer these questions more fully, in the second year of the Project we will formally follow groups of families receiving controlled, differential placement processes from the CCO.

CHAPTER III: CHILD CARE PROGRAM SERVICES

Concurrent with development of the Counseling-Coordination Office during the first Project year was development of the demonstration Child Care Programs. These programs were to function coordinatively with the CCO, and when all proposed program elements were fully operational, we would have a comprehensive, coordinated child care system within which we could study family utilization patterns.

Uncertainty as to just how comprehensive a child care system had to be and what coordination variables would be highlighted meant that program development would necessarily need to be based on a process approach. For example, we felt parents should have a variety of settings available for them from which to choose and we therefore planned for a satellite character to our demonstration Center which would include in-Center care, family home care settings and settings appropriate to the care of the school-age child. However, the exact nature of program developed within each of our demonstration child care settings has evolved from an amalgamation of parental feedback into the system and what Project staff has come to feel is in the best interests of children when supplementary and/or complimentary parental care is provided.

While it would have been ideal to have all subsystems of direct care becoming operational at the same time, the crush of start-up planning and problems precluded Project staff doing everything at once. Because the greatest call for care was for In-Center care, and because a center program was to be the hub of resources from which our satellite programs derived training and material support, this setting was the first to be operationalized. In September, 1972, the In-Center Program opened; in January, 1973, development of Family Home Care services was initiated, and in May, 1973, the first direct programming for school-age children began.

A. THE IN-CENTER MODEL

The In-Center Program was officially licensed as a children's center by the State Department of Social Services in November, 1972. This core component

in the demonstration child care system was the focus of considerable time and effort in our first year endeavors. As our initial and most immediately visible service model, demonstration of a quality, comprehensive and coordinated program endeavor here seemed to particularly warrant intensive and extensive development. Given this orientation, end-of-first-year experiential and data-based information emerges as being more plentiful around this model than it does around others in the system that were to emerge subsequently.

The In-Center Program is located ten blocks from the Medical Center campus in the converted obstetrical wing of the Booth Memorial Salvation Army building. Individual "patient" rooms have lent themselves nicely to the many offices a satellite system requires and to a "home-base" grouping concept in organizing programming for the children.

Parent involvement in the In-Center Program has been available at three levels: spontaneous visiting during the day on work breaks or at lunch hour; parent meetings specific to In-Center issues; and formal participation in the Project's Advisory Board.

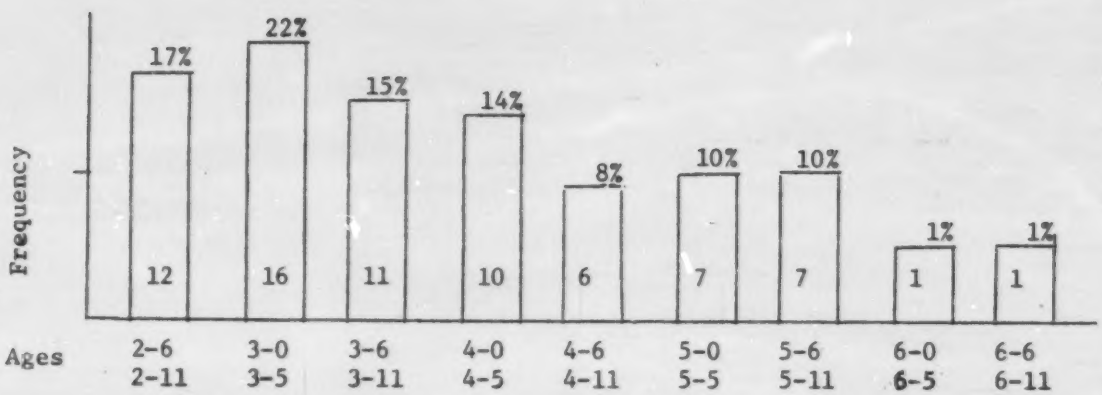
Fees for the In-Center Program have been determined on a sliding scale ranging from $15 to $40 for full time, five day/week care.

Follow-up of Children and their Parents
Using the Model In-Center Program

Descriptive Characteristics of Children

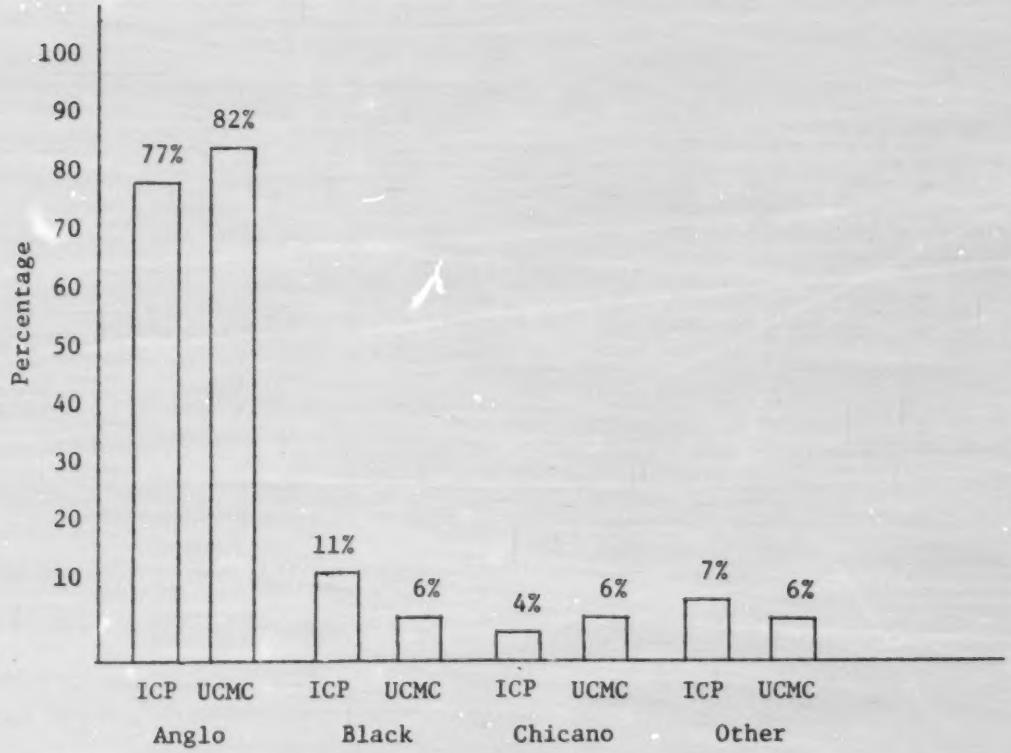
Seventy-one children from sixty-five families received full- or part-time child care in the In-Center Program (ICP) between September, 1972, and June, 1973. The majority of children in the ICP were between the ages of two years, six months and three years, eleven months - a figure reflective of overall calls to the Counseling-Coordination Office. The age breakdown at the time of enrollment for the thirty-two female and thirty-nine male children was:

Figure 4. Enrollment in the ICP by Age, September 1971-June 1, 1973.



Ethnic data suggests close, substantial agreement between enrollees in the In-Center Program and the total group of child-care eligible consumers at the Medical Center (Figure 5).

Figure 5. Ethnic Comparison of Children in UCMC In-Center Demonstration Program and UCMC Population, April, 1973



The seventy-one children represented sixty-five child-care eligible employee and student families; the majority of families were employees (65%) with four families of this group being of faculty status. Twenty-one children were from single-parent families; fifty from two-parent families. Of the two-parent families, ten children were from families where the mother was not engaged outside the home. Table VII compares children with one or both parents as to family income level.[1]

[1]The cutting point for higher and lower incomes was determined by the Outside Evaluation Team.

TABLE VII

Comparison of Children with One or Both Parents by Income Level of the Family

No. of Parents	N	%	Higher Income (> 8,000)	Lower Income (< 8,000)
One	21	30	4	17
Both	50	70	41	9
Totals	71	100%	45	26

Utilization Patterns

It was our experience that children were more likely to be enrolled full-time if they are age four and one-half or older with less than 50% of the children under that age enrolled full-time. Seventy-seven percent (77%) of children four and one-half and over were enrolled on a full-time basis. Table VIII depicts full-time and part-time enrollment by age of child.

TABLE VIII

Part-Time/Full-Time Enrollment in the ICP by Age (September, 1972-June, 1973)

Age	Full-Time		Part-Time	
2-6 to 2-11	5		7	
3-0 to 3-5	8	22	8	27
3-6 to 3-11	4		7	
4-0 to 4-5	5		5	
4-6 to 4-11	5		1	
5-0 to 5-5	4		3	
5-6 to 5-11	6	17	1	5
6-0 to 6-5	1		0	
6-6 to 6-11	1		0	
Totals	39		32	

Enrollment stability of the children in the In-Center Program was relatively high with ten children (14%) withdrawn. Of these ten, three were withdrawn due to a change in parental place of employment which then made the family ineligible for model services.

Follow-up conferences were held with parents to determine reasons for withdrawal. Seven of the ten parents involved withdrew their children for reasons other than those pertaining to eligibility for services. Factors in each of the withdrawals seemed multiple and individualized to the specific family. The reasons for withdrawal as determined from parent interviews consisted of the following:

Sex of Child	Age at Withdrawal	Reason
1. Female	5 years	Adjustment good. Frequent bouts of strep throat and otitis media leading to private physician recommendation for small group care. Mother ambivalent, but placed her in Family Home Care.
2. Female	5	Child missed her "old" child care center. As parents anticipated being ineligible for care shortly, child returned to former child care center.
3. Female	4 1/2	Adjustment good. During nap time, two other children "trimmed" her hair; since child had had meningitis as an infant and lost her hair, mother has placed strong emphasis on the child's hair. Charging inadequate supervision, the child was withdrawn.
4. Male	3 1/2	Adjustment good. Had a series of colds. Father was angry that the child did not always wear boots on the playground. Recent reapplication withdrawn because: "fee too high".
5. Male	3	Child was swearing and/or biting other children. When care-giver attempted to discuss this with the parents, they became offended.

6. Male	2 1/2	During an outbreak of diarrhea, the mother observed children not washing their hands before lunch. Ambivalent, but fearing health problems, the child was withdrawn.
7. Female	2 1/2	A part-time child (once a week) who had great difficulty separating from mother; it seemed that everytime she came, she "caught something".

With the group of children who remained enrolled, the length of time they were enrolled was compared to the time they actually spent in the setting. For various reasons, e.g., illness, vacation, etc., children attended the In-Center Program only 82% of the time for which they were enrolled. Variability in this percentage was wide in that the range was as low as 10% attendance for one child to as high as 100% for four children.

To study the broader question of whether characteristics of the family were related to a child's stability in the setting, we looked at attendance data by marital status and the mother's work or student status. While not statistically significant, there was a definite trend for children in single-parent families to have a consistent attendance pattern (85%). Children whose mother was not engaged outside the home had a low attendance pattern (65%). Children from two-parent families where the mother as well as the father was engaged outside the home fell between the two groups (83%), but a pattern more similar to that of children of single-parent families emerged.

In summary, the above results can be examined from a number of different perspectives. From the child's life experience, stable attendance may contribute more consistency to his life space thereby enhancing potential for growth and development. From a parent's perspective, motivation for using child care would appear to contribute to their utilization patterns, i.e., parents who work and especially those who can least afford to lose time and money from work or school appear more likely than others to have their child attend on a consistent basis.

Initial Needs Upon Enrollment

Prior to formal admission to a child care center, it is required by Colorado law for all children to have a physical examination. As a part of

our CCO process for this demonstration we also required that a comprehensive health history form (Appendix II) be completed by the family and taken to the physician which they had selected for the child's health examination.

We hoped that the health examinations required before admission to the ICP would ensure that the children would have had comparable screening across all health dimensions. While 77% of the children were under private physician care prior to enrollment, there was wide variability in whether basic health screenings had been completed (e.g., vision, hearing, developmental appraisal).

All children were evaluated by their physicians as being in good health with the presumed definition of health being that they were, at the time of examination, free of communicable disease. However, because we choose to believe that early detection and follow-up of developmental lags or deviations in vital channels (e.g., auditory, visual, motoric) and early prevention and treatment of health problems are important to maximal developmental progress, we were unwilling to appraise the children as being in a maximal state of good health without more complete information.

Further, while attention has been focused historically on the inconsistency of health care endemic to the "poverty population", we were concerned that health care services for middle class families (of which our study group basically consists) may not be that much better. While it may be argued that the incidence of deviations one might pick up in such a population does not warrant the time and effort required, our demonstration is, in part, concerned with determining if health screenings indeed do need to be part of a comprehensive child care service. And, if so, we are concerned with trying to determine how such screenings can be feasibly arranged.

In reviewing the children's physical examinations and health histories, we found that fifty-three (75%) of the children had not had simple vision screening prior to entrance. Locally, most pediatricians begin to incorporate vision screening at age four as part of the well-child check-up; yet less than half of the children who were four and over had received such screening. Seventy-five percent (75%) of the children also had not received a hearing screen; yet according to the University of Denver's Speech and Hearing Center,[1]

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[1]Personal communication

we could expect an incidence of deviation in approximately 5% (3.5 children) in our normal population of pre-school children.

Developmental screening of pre-school children in the areas of fine and gross motor functioning, speech and language, social-emotional and cognitive adaptive functioning simply was not a part of routine health examinations. Only one child had been screened and comprehensively evaluated for multiple problems (visual-motor, auditory and language functioning) and this child was one long known to area specialists.

Review of specific health history questions about dental care indicated that fifty-three (75%) of the children were not under regular supervision. According to the UCMC School of Dentistry, we could expect that over one-third of children would have cavities by age three in such a normal population. In our group, no child under age three was under regular dental care and only slightly more than half of those over three years of age were under such care.

Approaches to Screening and Findings

Coordinatively, the In-Center Program staff and the health subcommittee of the Project's Advisory Board met to strategize how needs for insuring comprehensive evaluation of all children might be met. The Board favored any system by which continuity of health care was maintained, preferably by one medical resource for each child. However, the Board allowed that parents might have individualistic needs about who they wished to provide services.

All parents were interviewed and indicated a preference for screening taking place via the resources that the ICP could muster from within the Medical Center complex. Primarily, this approach was more time-efficient for most parents; if many of the children were to be screened, either return to a private physician or other shopping around individually would be required.

Developmental screening. We felt that assessment of social-emotional and cognitive functioning of a child is understandably a time-consuming evaluation to obtain during a routine health examination; further, we recognized that

this kind of developmental focus is rarely a part of a physician's repertoire as contrasted with his skill in evaluating physical disease process. Therefore, the Project included such an assessment process[1] from the onset for this study group.

Initially, we felt that developmental information ideally might be obtained by the child's care-giver in the child care setting. Such an approach would permit training opportunities for child care workers and would enhance their in-person knowledge of child and parents. However, after trying it both ways - the CCO before enrollment or the child care worker immediately after enrollment - our decision was that obtaining such data before placement is more appropriate:

1) The information obtained would be highly useful in determining the characteristics of a child care arrangement which might fit better with a specific child; the process of obtaining information might also serve to sensitize parents to qualitative factors they may not have thought of in evaluating an appropriate placement based on child need.

2) Realistic time press on our own In-Center program personnel to provide direct care to already enrolled children most often precluded the child care worker sitting down with parents to obtain this information. We assumed the time-press would be no different in any other child care setting.

3) While child care workers with no formal child development background can be taught to obtain basic health and developmental data, interpretation of data into succinct implications takes consultative input from those skilled in integrating such material. From the efficiency standpoint - getting readily usable data to child care workers and rapid feedback to parents - it made more sense for the CCO staff to obtain and integrate the information, and to convey the material to the ICP either prior to or immediately after the child's enrollment.

In our experience with seventy-one children, the preliminary assessment revealed only one child with a significant delay (in speech and language) which required immediate coordination with special services and individualized approaches within the child care setting.

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[1] Screening tools used were: the Slossen, the Beery Test of Visual-Motor integration, the California Test of Social Competency, and the Denver Developmental Screening Test (DDST).

Dental screening. Initial contact was made in November with a School of Dentistry Pedodontist. Working with him and a dental hygienist, educational and service programs were established. The hygienist provided direct teaching to the children and staff of the Center while the pedodontist provided direct service to children and teaching of parents. All children enrolled at the Center as well as their parents and siblings could receive a dental screening examination if their parents wished. Results of the screening were presented to parents with an option of coordinating service needs into community resources or utilizing the School of Dentistry pedodontist for service on a fee basis. The screening program was without charge to parents and the Project.

Forty-seven (of fifty-three) children were clinically screened. Of these, nineteen (44%) were diagnosed as having cavities or other problems requiring treatment other than prophylactic care, e.g., regular flouride application. Seventy-eight percent (78%) of those requiring treatment were over age three years, 22% (four children) were under age three years. Four children requiring treatment were, according to parent report, already receiving regular dental care privately.

Vision screening. The head of the UCMC Pediatric Nurse Practitioner training program was contacted in an effort to coordinate their training experience with a vision screening program for our children who were age four and above. PNP students conducted the program along with one of our child care workers who was concurrently trained in the use of the Snellen E Chart and Ishihara Color Plates for color blindness. Materials for evaluating children under age four were not available.

Twenty-two children who were age eligible for screening were tested. Follow-up was needed for ten of the children tested. Of these ten, four had been screened prior to entrance at the Center. Of those needing follow-ups, two definite diagnoses were made of "no problem" - one by a private optometrist and the other by retest. One child was diagnosed as definitely having a vision problem by a private optometrist. Final diagnosis is pending for the remaining seven children.

Hearing screening. Coordinative efforts were begun in November with the Chief of Speech and Audiology at the John F. Kennedy Child Development Center. Target date for a screening program was set for December, 1972. However,

trainees were ultimately found to have such heavy responsibilities for previously existing JFK programs that it was not feasible for their time to be freed to evaluate Center children. The Pediatric Nurse Practioner trainees on campus were then looked to secondarily as a potential source for audiology screening. These trainees were able to provide such services time-wise but did not have the appropriate equipment. A portable audiometer, however, was obtained via loan to the Center by the Speech and Audiology Department at the University of Colorado in Boulder.

Parents requested screening on forty (57.9%) of Center children age four and above. Of the forty, 10 were judged to have too short an attention span to be tested. Of the thirty eligible, twenty-three (77%) were tested; the remainder were absent on the days when the audiometer was available. One child was judged to have a hearing loss as a result of the test. A second child had a hearing loss diagnosed prior to enrollment at the Center.

Conclusions about initial screenings. While our incidence rate of initially detected deviations in the areas of social-emotional, cognitive, hearing and vision were low, we did find some. Results of our dental screening particularly strongly suggest that early needs of our children are not being met.

If the child care movement holds to the importance of individualizing care as much as possible and ensuring a child's maximal state of health, it seems to us that, if all children entering a child care setting are not assuredly in "good" health, it then becomes someone's responsibility to determine that. Further, if one is concerned with a maintenance-of-health posture in a population with lower incidence of difficulties, it would seem that early screening and concern is an excellent reinforcer for ongoing parental sensitivity to prevention and early detection.

From our experience this year, it seems that either of several levels of intervention would be ideal:

1. That state licensing agencies require certain health screens to be a part of a health examination before enrollment - not just a statement of free of communicable disease. This approach would not only early sensitize parents to their importance, but conceivably would influence the physician to broaden his concept of a well-child examination.

2. That licensed child care settings be required to have internal or community resources available for initial screening and follow-up of children who are subsequently observed to have difficulties.

Given the current status of regulations for child care settings we feel that the responsibility for screening has to be assumed by the child care system. Even if parents use the private medical system, we feel that it will be some time before child care settings can expect that all children will be comparably screened before placement. Even if such was the case, children after enrollment typically show indications of deviations or physical illness for which screening resources are needed.

Emerging Needs After Enrollment

The Project was not only committed to determine what needed to be involved in a comprehensive pre-placement process, but also - through building of demonstration child care-giving services - to determine how comprehensive settings needed to be as based on perceptions of parents and/or staff.

We also stated that we would be family-focused in addition to our child focus and that we would follow emerging family-related needs as well as those of the specific child receiving direct care.

We found few families expressing any needs from the onset other than their desire for immediate child care placement. Less than 5% of parents articulated family-related problems while going through the CCO process with the majority of these being in some kind of acute stress for which immediate child care placement was perceived as "help" (e.g., recent marital separation).

In order to delineate specific parental input as to how they wanted certain procedures carried out for their child, we conducted interviews for purposes of tracking emerging concerns about children and/or their families; we kept anecdotal records on all children and developed a Parent Contact Form (PCF) (Appendix V) on which parent-staff interactions could be recorded. Illness and Absence Records (Appendix VI) were also kept and analyzed for all children.

Emergencies and frank illness. All parents were interviewed at the time of enrollment as to how the In-Center staff should deal with individual children should they become ill during the day. Every parent quizzed as to their

preference indicated they wished to be involved at some level in the process of diagnosing, treating and medicating their child. Parents' first preference, regardless of marital status or income level, was to have the Center contact them in the event a child showed symptoms of being ill. The overwhelming second preference was for the Center to contact the child's physician.

Some parents desired a convenience factor which would provide prompt consultation about their child with minimum time taken from their work or class. For those parents who wished this service, coordination via a pediatrician on the Advisory Board resulted in making available pediatricians in the UCMC Pediatrics Clinic who would be available for telephone consultation as requested by parents and/or Center staff.

While we used emergency procedures in only one case, knowing there is a close, efficient emergency facility for accidental crises, conveys a greater sense of underlying security for both parents and care-giving staff. Even though parents in the main had private physicians associated with a variety of outlying hospitals, it made sense to the parents and staff to utilize the UCMC emergency services just four minutes from the Center as a standard operating procedure.

Illness and Absence records kept on children for March through May, 1973, were examined for the incidence of moderate illness (e.g., strep throat, otitis media, diarrhea, chicken pox, etc.) and the relationship of incidence of disease to overall attendance. Eighty-eight incidents of absence were recorded involving 41 of the 71 children; only twenty-four (27%) of these incidents were due to moderate illness involving seventeen children. A significantly higher proportion of children from two-parent families were reported as having moderate illness (significant $< .001$); accordingly, we found that children from our higher income families were more often reported as having moderate illness and that they were being kept out of the Center for that reason (significant .10).

We expected children of our lower income parents to perhaps have a higher incidence of moderate illness. That our trends do not show this statistically does not mean lower incidence per se - perhaps illness in this group is not being identified, diagnosed or treated with the same degree of regularity as children in higher income families. For example, our informal observations of children who were sent to the Center with moderate illness suggested that

parents from the lower income group, whether recognizing the illness or not, still send their child to the Center - perhaps utilizing its services in lieu of losing work and/or finding alternative care.

Support for the latter hypothesis was reflected when data about alternative care was reviewed. From our Illness and Absence Record, we found that parents themselves had to provide the alternate care for over 50% of illness incidents accompanied by absence. In 38% of these incidents, parents lost sick or vacation time or actual wages. No pattern emerges looking at these parents by marital status or income.

We feel that our presumed incidence of disease being relatively low was also related to two prompt screening programs that were implemented mid-year. Children and staff were cultured for strep during the winter months as Denver climate is conducive to strep infections which are known to spread rapidly through children's centers. Care-giving staff were instructed by a parent consumer medical student in throat swabbing and cultures were sent to the State Department of Public Health for analysis without charge to the Center or parents. Sixty cultures were taken on forty children resulting in nine children (23%) diagnosed with positive strep cultures. Any time a child (or staff) complains of "sore throat", a culture is taken with the results referred to the medical service of the parents' choice.

A second free culture program was initiated with the Department of Public Health following inquiries to them regarding children with diarrhea. Thirty-eight children and sixteen adults were cultured including staff, parents and siblings. Fourteen (26%) positive diagnoses of shigella were returned. In both the cases of strep and shigella, we were able to promptly facilitate treatment and implementation of precautionary measures to prevent the further spread of infection.

Needs perceived by observation and parental concern.[1] While formal developmental assessment has not proved to be diagnostic of significant concerns at the outset, observations made on a day-to-day basis by child care workers do reveal emergent problems. Written anecdotal records kept by child care workers,

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[1]The children referred to in this section are other than those diagnosed in the previously mentioned screening programs though testing of these children may have followed identification of the concern by a child care worker.

together with their spontaneous verbal reporting, revealed twenty children (28%) over the course of the first year to have behavioral, speech, health or combined problems. We found that the majority of problems that concerned child care workers, and correlatively parents, were behavioral. Ten children were judged to have severe enough behavioral problems to warrant open concern, four seemed to have speech problems, two seemed to have chronic physical health problems, and four children appeared to have multiple problems (all involving behavior).

Of the twenty children represented in this group, those from single parent and low income families are over-represented in terms of the total Center population. Fifty percent (50%) of the children were from single parent families while the percentage of children from single parent families for the total Center population is 30%. Sixty-eight percent (68%) were from lower income families compared to 37% for the total Center population.

In determining what would be the most cost-effective and appropriate intervention regarding the problems these twenty children posed, we problem-solved using a case conference format with members of the internal In-Center Program staff. One of the main goals of such conferences was to determine if the pooled resources of the staff planning cohesively could effectively intervene in contrast to immediately reaching out for the "big guns". Eighty percent (16 of 20) of the cases were such that they could be effectively "treated" within the child care setting (e.g., all of the behavioral problems, all of the speech problems and two of the children with multiple problems). However, of the sixteen children for which special in situo programming was possible, eight of these cases required specialized consultation from Medical Center resources (four children with speech problems, four of the children with behavior problems). Only four of the twenty children were felt to have conditions warranting referral out to special Medical Center or community resources for assistance.

In addition to recording observations for staff feedback, concerns about children were also raised with their parents, and contacts recorded on the Parent Contact Form (PCF). This form was utilized in recording all parent-staff interactions regardless of content, who initiated the contact, between whom and about whom. The PCF's were used in two ways. First, as an important

part of the internal feedback loop to staff for use in general program development or problem solving, and second, to further investigate and document parental needs and concerns. For example, parents of the twenty children with the above mentioned staff-identified concerns had significantly more interaction (significant .01) with staff for each month their child was enrolled than parents of children not so identified. Overall as might be anticipated, there was a general trend for single and low income parents to have more interaction with staff than parents of other groups.

A general content and interactional analysis of the PCF's have given us valuable data across several dimensions. In analysis of the 661 separate parent-staff contacts which occurred from September 25 through May 31, we obtained a fairly clear picture of where mutual concerns were. For example, Table IX shows that social-emotional-behavioral concerns were most frequently discussed, followed closely by conversations about the specific mode of care being provided the child.

TABLE IX

Content of Parent-Staff Contacts at the ICP

Content	Percentage
Social-emotional-behavioral	37
Mode of care (philosophy, activities, structure)	31
Physical health	20
Social life of family	8
Parent participation in Center	4
	100%

The nature of how the contacts came about and what seemed to be the interactive process during the contact has been of interest to us in further understanding the "nature" of parents in raising quality concerns, and the concomitant

roles that child care workers seem to assume in functioning in the best interest of the child. Contacts were generally staff-initiated with this approach occurring 66.2% of the time. Eighty-four percent (84%) of the time these contacts were spontaneous and 95% of the time they occurred on a face-to-face basis.

We had tentatively expected that, over time, parents might take the forefront in initiating staff contact; however, our data shows that, in the first half of the year, staff initiated contacts with parents 62% of the time with assertiveness increasing to 69.5% in the second half of the year. Certainly our staff expressed a higher degree of comfort in seeking out parents over the passage of time; we wonder if continued staff assertiveness reinforces parents into a reliance-upon-staff mode rather than relationship-building wherein they as parents can be more forthright. Nonetheless, this pattern suggests that seeking out parents in an active way is a critical required behavior on the part of child care workers if their full understanding of a child is to more assuredly occur.

As was seen in the CCO consumer population, parental contact around child care issues continues to be mother-oriented (88.2% of the time). Fathers have been involved individually in only 10% of the contacts with both parents simultaneously involved only in 1.2% of the contacts.

The process nature of the contact was also examined, i.e., within what context was the contact couched. Spontaneously giving information that they felt the other should know about the child occurred in 93.5% of the contacts. Asking specific questions of the other during the contact occurred in 20% of the contacts; 33% of the time contacts involved a matter that required joint problem solving. It is interesting that 33% of the time the parent-staff contact was initiated under the pretext of a social contact.

Significantly and, as would be expected, an overwhelming majority (85.5%) of the contacts started out with talk about the child enrolled in the Center. However, in 15.5% of the contacts the subject of the conversation also involved the parent per se or another family member (13.8%). Project personnel, most often a child care worker, was discussed in only 8% of the contacts.

Another interesting aspect of the data was that which compared parents who were members of the Project's Advisory Board. We found that these parents were more active with the average number of contacts per month of this group of nine parents being 3.14 compared to an average number of contacts per month of 1.93 for those parents not similarly involved.

Certainly our parent contact and interaction data is rudimentary and subject to many realities; we feel that the time press in daily care-giving undoubtedly interfered with as many PCF's being submitted as actually occurred. Aside from the increased knowledge they have provided for us about parents' relating patterns, we have found the PCF system to sharpen observational skills of child care workers, to provide on-going data on children recognized early as having something about their behavior that is concerning, and to ensure that parents are informed.

Conclusions about on-going needs. The data from tracking our children and their families over a period of time strongly suggests that staff must keep a sharp eye beyond evaluation at the time of enrollment and that staff initiative is very important in bringing concerns to the attention of parents.

Of the children about whom staff raised strong concerns about their development, behavior or general health, we did find that the majority of the children were responsive to interventions brought to bear within their child care setting; however, we are appreciative of the fact that we felt that, in 40% of the cases, we required outside consultation to accomplish that. We also appreciate the fact of needing to be knowledgeable about community resources in referring children for special assistance when specialized outside appraisal is necessary. The effort in making consultation available and developing a knowledge bank of specialized services to which parents can be quickly referred is described in the following section. However, going through the process made us quickly realize how vital what we had already organized would be to our satellite school-age program and particularly to our here-to-fore isolated family home care mothers.

Our data also suggests that parents will use child care settings as a support system to varying degrees. We have been impressed with the increased number of child-focused concerns and interactions occurring with parents who are single. Perhaps because there is a strong need for single parents to

have someone other than themselves with whom to problem-solve, the Center appears to be asked more by this group for support in maintaining a sense of cohesion and consistency in their child's life. As our single parents are also the greater share of our lower income group, we suspect our tracking data over a longer time period will indicate that, if for no other reason, child care settings should have comprehensive resources built-in to meet the needs of this particular group.

Finding and Coordinating Specialized Services

With regard to coordination of specialized service delivery in the model Child Care Center, the Project turned to the vast resources of the UCMC and especially to its extensive training programs. Mobilization of this resource reservoir proved initially extremely time consuming and involved major feasibility issues:

1. While the UCMC appears a cohesive whole to the outsider, each department within has its idiosyncratic policies, practices and philosophies which require quite different negotiations from the onset. Indeed, each department might best be viewed as if it were a unit existing independent of the whole.
2. Service press varies from department to department but generally speaking is so great on staff and trainees that new programming requires extensive "lead time" prior to actual implementation if coordination is to be at all feasible.
3. As the population of children and families using child care is essentially "normal", we have found departments that are oriented about a "crisis" or "problem" model and difficult to mobilize before the fact.
4. To the extent that a department's priorities change, programs for service delivery may be set aside or given lower priority.
5. While there is a real plethora of qualified trainees on the UCMC campus, engaging such a trainee to deliver specialized services becomes a matter of timing of a family's or child's need to a training schedule. Most UCMC training programs operate on a semester basis. Need-meeting must coincide with "critical periods" for the trainees for maximal service delivery to take place. Continuity with families involving diagnosis and follow-up appears less feasible for trainees where a training program may end before a need has been met. The burden then, of continuity, falls on whomever is coordinating service delivery and, to the extent that trainees rather than UCMC staff are utilized, this presents a major effort.

While the resources were there and our Project was a part of the Medical Center, we often felt that we were no different than any other child care

setting within the community who had set about to obtain assistance from the complex. The fact remains that we were able to mobilize resources eventually and to develop some practical suggestions.

Screenings. Project staff have found screenings to be minimally time consuming and intrusive into daily programming; particularly with vision and hearing screenings which can be fun procedures for children as integrated into activity programs concerned with learning about body parts.

Project staff have found vision screening to be uncomplicated; it can be competently done by paraprofessionals who have been properly trained. A Snellen E Chart is inexpensive and proper training is available from physicians and public health nurses in most communities. With respect to hearing screening, due recognition must be given to the fact that such screening can be done only by those so trained - i.e., generally, speech therapists, Pediatric Nurse Practitioners, Child Health Associates and physicians. Coordination of such a program might involve inquiries to a speech and hearing clinic or to a public health agency if one is available in a community. Minimally, an educational program to sensitize parents to request such a hearing screening from their own physician would be recommended, especially for children who have had chronic middle ear infections or delays in speech development.

The services offered by the State Department of Public Health are not unique to Colorado. An informal survey of the Denver metropolitan area revealed that no other center was taking advantage of the free diagnostic services offered by that department for strep detection and control. This program is inexpensive and paraprofessional personnel are easily trained to swab throats by professionals in most any of the health related disciplines. The lack of expense and effort involved in the program make it one that can be recommended for any care-giving setting.

If a dental school is not immediately available, Project staff feel that dentists in private practice might be contacted through the local dental society to see if they or their hygienists might wish to pursue a diagnostic screening program. Coordination of such a service might be even more feasible if the costs could be passed on to the parents with a center or family home care mother actually contacting, arranging for and providing transportation to enable the program to become a reality. If coordination is not feasible, we strongly

recommend that persons caring for children present an educational program to parents to sensitize them to early diagnosis of dental problems and also make referrals to dentists in the community. Inexpensive and effective in early sensitizing of staff and parents as they entered a child care system was our including questions about regular dental care within the health history form.

Obtaining resource persons from which to learn how to do developmental assessment (or finding the time to do it) poses a somewhat more difficult problem. In our particular Project, staff from the CCO had the capacity to do this and to train child care workers. Because of the Medical Center's unique resources concerning child development (the John F. Kennedy Child Development Center and Frankenberg's Denver Developmental Screening Test [DDST] research and training unit), we could have reached out for assistance here. We are also aware that public health nurses in the metro-Denver area as well as in the state of Colorado are well versed in the Denver Developmental Screening Test - an unusual situation relative to the country as a whole. Outside of our regional area, we would suggest contacting public health agencies or any university or associate degree program which offers a child development major for their actual direct service assistance or referral to persons in the community who may have these skills.

Emergency facilities. From our experience in deciding on one emergency facility, it seems reasonable for any child care setting to utilize the nearest resource available for all of the children in their care. Prior contact with this nearest facility for purposes of informing them of the child care facility being in the area and finding out what their admittance policy is can be crucially time saving in an emergency when anxiety is high. In our case, we had all parents fill out the necessary admission forms and obtain clinic cards (which we retain); this has allowed us to inform parents, take the child promptly and meet parents in the emergency room. Not having to focus on filling out papers at such a time has allowed child care staff and hospital personnel to focus more on the emotional support needed at such a time.

Consultation. The two most heavily used professional consultants coming into our program thus far have been psychologists and speech and language

therapists (in that order). Because of the requirement of each family having a physician to contact, we have experienced ready consultation for general health problems via phone. We have found this kind of physician-phone consultation to be very cost-effective. However, with specialized behavioral and speech and language problems, the kind of consultation we have received would be cost-prohibitive if it were not for the trainee resource base from the Medical Center. Faculty from the Medical Center (or any other academic institution in the area) can not afford the time for direct in situo consultation. While we have many private practitioners in the metro area, these professionals cannot afford the lengthy consultation that certain cases require without receiving compensation. With the number of cases having definitive concerns which emerged that could be effectively ameliorated within the setting with consultation, we feel that many "normal" children throughout the country are going unattended in their early years simply because of the lack of a necessary resource. We would like to see state regulatory agencies and 4-C groups work toward sensitizing state governments to the financial assistance that will be required before necessary consultation can be made equitably available. Regionalizing both consultation and developmental assessment resources through a network of counseling-coordination offices or a network of comprehensive child care centers with satellite family home and school-age programs conceivably would enhance overall cost-effectiveness.

Evaluation of the In-Center Program

The Outside Evaluation Team and personnel involved in internal formative evaluation of the Project conducted several studies to determine parent and staff perceptions of the demonstration In-Center Program (ICP) within the Child Care Center. The overall rationale for these studies was our commitment to utilize evaluation feedback in a self-correcting fashion as part of effective process research. The three studies which are herein discussed include:

1. a Quality Criteria Study (internal formative evaluation)
2. an Outside Evaluation Survey
3. an Internal Evaluation Survey

Quality Child Care Setting Criteria Study

The purpose of this pilot study was to evaluate the extent to which parent consumers and Project staff judged the ICP to be meeting our forty-six Quality Child Care Setting Criteria (Appendix I). The study is viewed as a pilot endeavor for two reasons. First, as less than one year has passed since the Center was established and since significantly less time has passed since its stabilization, it is felt that results must be viewed as preliminary. Second, the instrument involved is in an early developmental stage. Some of the criteria need expansion, others need clarification.

Seventeen staff members and fifteen parents participated. Staff were divided into two groups according to whether they had direct or indirect involvement with the daily operation and families at the In-Center Program. Group A staff had direct involvement; Group B staff had more indirect, less immediate involvement with both children and their families.

The parent group (Group C) is smaller than had been hoped for; thirty sets of parents who were using the Center were randomly selected and contacted. Of these thirty, fifteen returned the questionnaire. The remainder of the selected families were either on vacation or unavailable to participate. Two families returned the questionnaire after data analysis had been completed. Review of their responses revealed no significant differences from the total parent group and thus they were not included. These fifteen respondents were representative of the total parent group with regard to both marital status and income level.

Staff and parents were given a list of the forty-six criteria and were asked to indicate "yes" or "no" as to whether the In-Center Program met each. Table X illustrates the mean number of criteria the Center setting was judged as meeting by each of the groups.

TABLE X

Group		N	Mean	Range
Directly Involved Staff	A	11	41.3	11
Indirectly Involved Staff	B	6	30.8	14
Parents	C	15	37.2	26

From Table X, it can be seen that those who work most directly with children and families (Group A) judge the setting as meeting more of the criteria than do either Group B (Indirectly Involved Staff) or parents (Group C). (Appendix VII illustrates the percent of each group who indicated that the model service setting was currently meeting each criterion.)

An emergent picture of the ICP and staff attitudes does derive when one looks at directly and indirectly involved staff responses to specific quality criteria. While it is possible to discuss findings relative to each category of criteria involved, an effort is made herein to pull out illustrative issues and trends that are inferrable from this data. Hence, the following narrative is not intended to be exhaustive.

While the ICP tends to be perceived by both Group A and B as convenient to parents in the process of going to and from work, there is less consensus across these groups that the ICP is convenient in terms of parents being able to see their child during the day. Parents themselves are also less certain of the convenience of seeing their children. Relative to this issue overall, however, direct staff (Group A) are the most skeptical. This view of Group A may be a result of their desire to see more extensive parent involvement on a daily basis and/or it may be reflective of a broader staff concern that

communication with parents on a day-to-day basis is not as adequate as they would like it to be.

Due to the existence of back-up personnel in the ICP to fill in when a child care worker is unavailable, both staff groups perceive parents as losing no time from work or school. However, less high and discrepant ratings are given by the two staff groups as to whether parents have to go through a complex process of care-giving replacement when the child is ill. Direct staff (Group A) see such care-giving replacement as less complex probably due to the fact that they have not been the group within the staff which has struggled to find in-home care resources in such emergencies. Group A's lack of direct experience in working through complex arrangement processes with parents may also be contributing to a similar discrepancy in ratings between the two groups concerning parental perception of child care fees being "feasible." For example, only 33% of the indirect staff feel that parents perceive the ICP fee as feasible even though it means sacrificing basic necessities while 64% of Group A feel that parents perceive it as such. Parents (46%) tend to agree more with the Group B staff (indirect) which has had more direct experience with fee negotiations. It may be that Group B recognizes that, for some families at least, the fee may require deprivation of what parents perceive as basic necessities.

State regulations are implemented in the In-Center Program in daily practice. Yet some directly involved Group A members appear to question this despite the fact that the Center is state licensed. This feedback has led us to review with Staff A exactly what criteria are required and which are those that the Project feels are important in enhancing a quality milieu.

With respect to formal systems to ensure a safe environment for children, both Staff A and B tend to agree that such exist; however, indirectly involved Staff B does not feel that all that might be feasible is being done to prevent accidents and injury in an anticipatory and supervisory manner in the use of equipment in individual/group activities.

The two staff groups disagreed most dramatically with regard to whether or not the ICP reflected a child-family focused philosophy of care-giving. For example, indirectly involved staff seriously question if the ICP has: 1) a definable process used to facilitate a child's phychological move between

family and the setting, 2) whether care-givers are sufficiently familiar with families to facilitate their acting as a family advocate should this become necessary, and 3) whether staff attitudes reflect a family-complementary rather than supplementary child care approach. Yet the two staff groups tend toward more agreement about whether the milieu reflects appreciation of the families' ethnic, cultural differences and values. This concensus might derive from the ethnic mix of the Project staff with both staff groups thereby assuming that this representation of people satisfies the criterion. That parents tend toward agreement with the directly involved Group A staff about a child-family focus suggests either 1) that directly involved care-givers indeed are more competently carrying out such activities on an informal basis than Group B is aware or 2) that parents are more satisfied with minimal concern in this area than Group B thinks they should be.

A similar pattern of more agreement between parents and directly involved staff than between the two staff groups emerges when reviewing the data concerned with programming which integrates health, social, emotional, cognitive and motivational needs of the child. Indirectly involved staff (Group B) definitively seems to feel that there is a long way to go in meeting children's individualized needs through an interpersonal process; additionally all of this staff feel that feedback from developmental assessment and parents has not gone into individualized planned experiences.

In rating formal systems to provide child and family specialized services, Group B (indirect staff) tends to perceive them as not as intact as Group A. As in the fee negotiation process, this phenomena may be related to Group B's direct "behind the scenes" involvement in trying to make such systems possible and their thereby being more aware of such systems as not being as comprehensive as they had initially envisioned.

An overall view of the ratings suggests that, for the most part, parents are in more agreement with directly involved Group A staff than with Group B staff. Exceptions to this occur with respect to lower parent ratings about fees; whether there are formal educational programs for parents; whether there is availability of professionals within the setting for formal evaluation, training, parent education, and whether there is a formal communication and transportation system to facilitate a child receiving special services outside of the setting.

Group A and Group B have at least a thirty percentage point discrepancy (range: 31-91) on seventeen (37%) of the forty-six criteria items. These discrepancies are all in the direction of Group B perceiving criterion not met as adequately as does Group A. Ten (59%) of these criteria items fall within the categories of child-family focus (5) and programming for the individualized child (5). The theme of all ten of these items pertains to the social-emotional sphere of living.

Before firmer conclusions can be drawn from such data, refinement of the criteria to include mutually understood terms and operationalized definitions is necessary. However, it appears that Group B's general response patterns demonstrates their social-emotional emphasis in child care and, concurrently, their higher expectations. In view of parents being more satisfied with the present level of concern shown in these areas and direct caregiving staff approximating their appraisal, it becomes a moot question whether indirectly involved staff's "concern" is warranted. More formal study of the relationship of "quality" criteria to "satisfactory" child care in Year II may provide more clarified insights. At this point, our thinking about discrepancy ratings cluster around three dimensions which seem particularly germane:

1. Distance from the setting. Group A is closest to the daily operation of the Center and thus is most familiar with its practices and policies. However, in responding to this evaluation and in recognizing the significant and functional role they play, child care workers were actually evaluating themselves and their own job performance. It is expected that they might take a somewhat defensive posture in their responses and be more likely to indicate "yes" in the forced choice format. Within Group B, distance also seems to play a significant role. There is a definite trend for fewer of the criteria to be rated as being met as one moves away from daily operational involvement at the Center.

2. Knowledgeability. Group B is significantly more knowledgeable vis-a-vis child development theory and practice than Group A or parents with five of the six people involved having had extensive educational and/or experiential background in this and related disciplines. This group also had a major hand in developing the forty-six criteria. Their knowledge bases may have led to harsher, more idealistic judgments. Further influencing this may be the fact that parents as a group do not feel they know what to look for regarding quality care in evaluating a child care setting as our initial Project survey data suggested (and as our parental reticence to raise quality issues may reflect.)

3. Priorities. It would be naive to assume that all three groups would weigh the criteria in the same way. Research from other disciplines suggests that what parents and professionals view as "important" is often quite discrepant. Implications for further evaluation in this area are obvious in order to fully understand what accounts for the discrepancies between the ratings of the three groups.

Outside Evaluation Survey

A parent survey of fifty-three families was conducted by the Outside Evaluation Team as part of their Incremental Summative Evaluation (ISE). The families were categorized by family income (as above or below $8,000) and in terms of when the child was enrolled (as prior to or after January 3, 1973).

Table XI gives the number of available families in each category as well as the number returning opinionnaires.[1] Appendix VIII indicates the parameters involved and tabulated parental opinions.

TABLE XI

CHILD CARE CENTER

PARENT SURVEY DESIGN

	High Family Income $8,000-24,000+	Low Family Income 0-$7,999	
Early Users (prior to Jan. 3, 1973)	Families Available: 16 1/2	Families Available: 11	Available 27 1/2
	Opinionnaires Returned as of 6/8/73: 11	Opinionnaires Returned as of 6/8/73: 7	Returned 18
Late Users (after Jan. 3, 1973)	Families Available: 12 1/2	Families Available: 13	Available 25 1/2
	Opinionnaires Returned as of 6/8/73: 6	Opinionnaires Returned as of 6/8/73: 9	Returned 15
	Available 29	Available 24	Families Available 53
	Returned 17	Returned 16	Questionnaires Returned 33

[1] As of June 8, 1973, thirty-three opinionnaires (62%) had been returned. Within each of the four cells, responses took on enough consistency that the Outside Evaluation group did not feel the need for additional follow-up of non-respondents.

Summarizing the major findings of this study, the Outside Evaluation Team concluded that the In-Center Program had been particularly well-received by parent users. Parents seemed to feel that the Center had succeeded in keeping them interested and involved in their children's program. Late entrants into the Center felt more positive about this than did those who had been enrolled for a longer period of time.

In initial phases of the Project, we speculated that parents might feel more involved with the program if they were demonstrable in their involvement, e.g., attending the Advisory Board and parent meetings. Yet, as the Outside Evaluation Team pointed out, a surprisingly large percentage of late entrants have never attended these functions in contrast to earlier entrants. It may be that later entrants experience a program at a point when early "wrinkles" have been worked out and that their feelings of "involvement" are thus evidenced from daily contacts rather than attendance at formal input meetings.

While parents generally have felt "involved", this concept does not necessarily mean that parents have felt that their opinions could affect program change. Higher income parents were more definite in their opinion that what they have to offer can affect change and this group, together with early entrants, have offered the greater share of suggestions for improvement to the staff.

Parental satisfaction with the Center can be derived from several standpoints. For example, they appeared to be satisfied in that most had recommended it to at least one friend and over one-half of the group indicated that their child would remain in the Center next year. Most of those indicating they would seek another center were going to do so because of moving. The majority of parents (91%) indicated that they were pleased with the abilities of the staff members working with their children either a "great deal" (52%) or "most of the time" (39%). Obviously the children of these parents enjoyed (were "satisfied") being at the Center either a "great deal" (63%) or "most of the time" (34%). Satisfaction might also be inferred from the fact that 91% of these parents felt that the cost of care approximated its value. However, "satisfaction" was not so strong as to hold under the possibility of a $5/week tuition increase; only 33% of all parents definitely said "yes" and 42% were "uncertain." Interestingly, 25% of the lower income families definitely said "yes" with 50% indicating "uncertain."

Internal Evaluation Survey

Direct, open-ended feedback of the In-Center Program was solicited as part of internal evaluation in May, 1973. Fifty-seven families (or 100% of families with a child currently enrolled at the Center) were contacted by mail at their home address and were asked to respond to the following four questions:

1. Positive aspects of the Center's program for my child(ren) or myself (ranked).
2. Negative aspects of the Center's program for my child(ren) or myself (ranked).
3. What more do you feel this Project could have feasibly offered your child(ren) or your family?
4. What kinds of things do you feel this Project should not have offered to your child(ren) or your family, and why?

The open-ended format served two functions: (1) it maximized input prior to possible biasing effects of the Quality Child Care Setting Criteria Study (forced-closed format) and (2) it provided valuable parental input into revision of the Setting Criteria.

Twenty-one (36.2%) of the feedback questionnaires were returned yielding a total of eighty-six comments about the ICP. Sixty-two (72%) comments were made by parents of a positive nature vis-a-vis child(ren) or self (parent). Of those related to children (63%) twenty-nine mentioned the Center's program; ten mentioned personnel at the Center. Nineteen (31%) comments were made that reflected parents' perception of positive aspects of the Center which affected themselves. Of these, sixteen related to the program; three related to personnel. Four comments cut across child and self (i.e., parent) subcategories. Frequency comment categories follow:

Frequency of Positive Comments

		N
1.	Socialization experience for child	15
2.	Learning experience for child	9
3.	Parent participation	6
4.	Convenient for parents	5
5.	Staff available to parents	3
6.	Staff gives personal attention to child	3
7.	Flexibility (unspecified for parents	3
8.	Trust in staff	3
9.	Comprehensive delivery of services	2
10.	Other	8
		62

Additional positive comments were scattered and included such items as field trips, low cost, illness and absence policy, parent accessibility to the child and to nice surroundings. It should be noted that, while a high Project priority is delivery of comprehensive services, only two parents spontaneously mentioned this as a positive aspect of the Center.

Twenty-four (28%) comments of a negative nature were made by parents. Of these, seventeen reflected dissatisfaction with aspects of the Program (11) or personnel (6) which affected children. Six comments were made reflecting dissatisfaction with the program (5) or personnel (1) directly affecting the parents. One comment cut across child and parent categories. Negative comments can be broken down into four general areas of concern.

Frequency of Negative Comments

		N
1.	Supervision of children involving reasonable discipline	5
2.	Lack of structured activities	4
3.	Cost	3
4.	Medication administration	2
5.	Other (scattered)	10
		24

Only nine parents responded to the question on what more the Project might offer. Two distinct patterns emerge in looking at these comments: (1) increased programming, facilities or procedures related to children who are ill and (2) additional attention or activities at various times during the day. Two parents mentioned fee adjustment; one mentioned additional parent groups.

Three parents commented on what the Project should not have offered. One of these comments involved something not under the Project's control, i.e., influence of other children who have "bad" habits. A second comment requested that the Project not accept (or allow ongoing enrollment of) children with behavioral difficulties. The third comment related to the paucity of parent comments on comprehensive delivery of services. This comment called for less time spent on such service delivery and for more emphasis on "FUN" activities which "help children develop physical and mental abilities."

Summary and Discussion

All three of the above surveys involved use of parents as primary respondents. The Quality Criteria Study additionally yielded a contrast of parental opinions with those of Project staff.

Overall intent of the three surveys pertained to our need to determine evaluative views pertaining to the In-Center Program that would yield self-correcting type information that could be fed back into the system. The essence of the primary findings resulting from the surveys consists of the following:

Overall, parents definitively indicated positive feelings of satisfaction with the In-Center Service Model Program (both with respect to parameters of that program that affected their child(ren) and to parameters that affected themselves as parent consumers). Parents and directly involved Project staff tended to reflect basic consensus in views with indirectly involved Project staff being somewhat more "critical" than either of the other two groups in evidencing higher levels of expectation relative to standards for a quality demonstration child care service program.

Such parental concerns as were tapped by the three surveys tended to be of rather specific natures - e.g., concerns about issues of need for more structural

activities, for more adequate supervision and discipline, for more Project concern about children who were viewed as being a "bad influence" on other children, for enhanced planning of procedures for children who became ill.

Higher income families indicated the greatest sense of feeling that their input could effect program change. This group and parents whose children were early entrants into the program were those who offered the most suggestions for improvement to the staff. Interestingly, however, lower income families rather uniquely emerged as the group expressing most willingness to try to continue on with enrollment of their child(ren) in the In-Center Model Program should a $5 a week tuition increase occur.

Parents of children who were later entrants into the program tended to reflect that their sense of interest and involvement in the Center derived from a daily-contact type of basis. In contrast, parents of children who were early entrants evidenced a sense of interest and involvement as deriving more typically from attendance at formal-input type meetings.

Clearly, the above kinds of trends in information resulting from the three first-year surveys cannot be viewed as conclusive in any sense. Nonetheless, they do provide highly valuable perspectives on various facets of the In-Center Service Model (i.e., in identifying particular programmatic and personnel strengths and weaknesses and in descriptively characterizing some differences in orientation across various basic groups of people.) While such data is considered to be relatively unsophisticated and tentative, it is also felt to offer important, initial feedback guidelines for seeking second-year improvements.

B. FAMILY HOME CARE MODEL

Our original proposal called for recruitment of Family Home Care (FHC) trainees who had not previously been in FHC and provision of a full-time, stipended two-month training program for them. At the completion of the training program, the Project would offer assistance and consultation to these child care workers in their satellite homes and refer consumers from the CCO to them as appropriate.

Recruitment Realities

Goodwin and Glass[1] have accurately and succinctly described our early experiences in trainee recruitment as, "the expected deluge of applicants turned out to be in reality, a trickle." Our recruitment efforts included leafleting shopping centers in the East Denver area (which brought six inquiries and one application), news releases to media which involved ten radio stations, four television stations and three newspapers (which netted thirteen inquiries and one application), and personal visits to Action Centers and licensure agencies. We found that these methods do not reach mothers at home who are looking for a way to be with their children and still earn extra income (and who, in our fantasy, were just waiting for a program such as ours to help get set up in business).

All of our eventual trainees learned of us by word of mouth - through a staff member of the Project or another trainee. Thus we learned that, while the mother of our fantasy may in fact be there, reaching her is a long, slow process requiring face-to-face contact. While we ideally wished to start trainees in groups of at least four, we finally decided that rather than lose more potential applicants, we would accept trainees as they became ready, and tailor training experiences to fit each individual need.

After our initial three months of less-than-fruitful publicity efforts in recruitment, we decided to broaden our concept. If we could not immediately

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[1] Goodwin, William and Glass, Gene. Incremental Summative Evaluation of the Comprehensive, Coordinated Child Care Project. Bureau of Educational Research, University of Colorado, May, 1973, p. 64.

tap into a group of people who wanted to become FHC workers, then let us tap into the group of people who already are FHC workers and who have needs for "relatedness" to our comprehensive Center. We did not have staff time for the door-to-door canvassing used by Sales[1] to recruit participants. Thus, we tried letters to fifty-nine licensed Family Home Care mothers (FHCM's) in our immediate Medical Center area, but received only three replies (two of which involved persons who had already become acquainted with the Assistant Director for Family Home Care at another time). Our most productive method to date has been personal visits 1) to the local Association of Family Home Care Mothers (called the "Infantree") and 2) to Blackwell's EPDA project group in FHC training classes.[2] Seventeen FHCM's contacted from these groups indicated enthusiasm and interest at the onset.

Because of the experience in recruiting from scratch versus recruiting already-existing Home Care mothers, Project staff concluded that:

1. For purposes of the demonstration model Center, the least time and cost expensive route to pursue was to recruit existent, but "needy" Family Day Care mothers.
2. Motivational factors as to why people become and stay Family Home Care workers could be further studied with our recruited mothers. The methods we had utilized, including a "comfortable" stipend, meals and free child care, had not hit the mark.

Training Realities

Our initial group of full-time, stipended trainees involved four people who joined the training program at intervals of one to four weeks. They presented a rather classical picture of the FHC mother - they were all female, had a mean age of 24.7, three had one child of their own and one had two children (all were pre-school age). Two had employed husbands living in the home; all had a high school education (and one had an additional year of college). While they appeared similar in demographic characteristics, personality-wise they presented a widely varied picture. They brought with them widely variant

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[1]Sales, June. I'm Not Just a Babysitter. Pacific Oaks College, Pasadena, California, p. 83.

[2]Blackwell, Audrey. Personal communication, June 8, 1973.

attitudes on discipline (some believed in spanking, another looked horrified at the thought), and on what child care is all about, what it's for, and what effects it might have for a child. But they all enjoyed children, doing things with them and learning more about them.

Trainees spent a total of eight hours per week in a classroon/discussion group, four hours in individual study, and the remainder of the time in practicum experience with children (Appendix IX).

Practicum Settings

Arranging the most appropriate practicum experience for trainees who would eventually be implementing their learning in their own homes (or in homes of a child's parent) derived from our early thinking that:

1. Their experience should take place where quality models of care exist and where there is maximal opportunity to learn (ask questions, try out their own ideas, etc.)
2. Their experience should reflect as many realities as they will encounter in their homes (e.g., experience with ages of children they desire to care for, setting restraints, etc.)

We felt a combination of in-center practicum experience as well as experience in already-existent family day care homes would be useful. Our demonstration In-Center service was ideal for a portion of the practicum and would from the onset, link trainees up with a group to whom they would ultimately be "satelliting". However, experiencing actual working with a stable, effective FHC operation would clarify realities and solidify identification with the home care approach.

Providing in-center practicum immediately posed no problem as the demonstration In-Center Program had been developed around the eventual entré of trainees. However, our lead time in preparing for adequate family home practicums was much too short. The process of finding, interviewing and arranging practicums in geographically accessible homes took approximately four weeks.

Just prior to the trainees starting, we finally found three local FHC mothers whom we considered to give excellent care and to be highly worthy of emulating. They were very interested, but they too needed lead time to prepare for what to them was an unusual opportunity. We found these mothers to be very conservative around their own needs for concentration on the job at

hand, and they felt the presence of too many strangers in the home during a short time span might disrupt the children. They were more than willing to make specific commitments for Fall, which would give them time to prepare the children and their own lives, but they were very definite about refusing to make significant changes in their operations on short notice. We found this phenomenon both frustrating from the point of view of program-planning, and heartening, i.e., that they felt self-assured to the point that they would consider the needs of their children and themselves before their desire to become a part of a training program and be cast in the role of "professional" and "teacher."

The restriction of practicum to an in-center setting was not a negative experience even though we had wished for more breadth. It did sensitize us to emphasizing differences more definitively in discussions and readings. Several times during classroom discussions of specific activities which trainees had carried out with children in the Center, they remarked that this could easily be done at home as well. Over time, much of the magic and exclusivity of Center care programming was lost, and our trainees were able to see that the program they could offer at home could be equally as stimulating and educational and might even surpass Center programming around the dimensions of physical milieu and consistency combined with spontaneity. "As a matter of fact," said one trainee as she prepared to complete her training, "I think that once parents realize all the things we offer, they will prefer FHC to Center care."

Identification with a "Profession"

Sales[1] and Blackwell[2] both speak of the FHCM's struggle for a feeling of status and importance to their work. Blackwell, in her EPDA supported training program for FHC mothers at Denver's Metro State College, begins each semester series with a class on "self-concept" to assist the FHCM's see the importance of their work. However, there is no evidence that wavering self-concept has occurred at the outset with our trainees. The built-in committment to provide

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[1] Op. cit.

[2] Personal communication, January, 1973.

"identity" and support in critical areas after training (consultation, specialized service resources, etc.) may have ameliorated the trainees' feelings of lesser importance.

The last trainee joined the group four weeks after the first. During the first discussion group, the other trainees evidently realized just how much they had learned and how much their own perspective had changed. They answered the new trainee's initial questions with assurance and corrected her reference to "babysitter" with, "We are not babysitters - we are FDCM's - we offer a lot more!" It seemed that an aura of healthy identity settled on the group that day. This was confirmed when the group spent some time in a toddler center in another part of the city. On their return, they immediately expressed to the Assistant Director of Family Home Care that the personnel at the other center "just weren't professional" referring to their observations that they did not keep adequate records on the children, did no developmental testing, they did not arrange toys and activities with an awareness of traffic patterns, visual stimuation, etc.

Within our own In-Center Program, trainees broadened and enriched our staff meetings and formal discussions of an individual child's progress and needs. They reinforced the perspective of "home" which is used throughout the Center - the use of common articles for a variety of learning experiences, assisting children to understand what being "younger than" or "older than" another child meant, and the skill required to involve children in some housekeeping chores and to allow them to be independent though carefully supervised when record-keeping or maintenance duties arose in which children could not participate.

Trainees watched our own In-Center workers carefully as models of interaction with children, for room arrangement, for useful techniques in dealing with groups of five or six very lively youngsters, for new ideas for activities and for ideas for making activities more complex, such as adding to sandbox play with extra props. There were times when they were critical observers - they expressed the intention of doing some things differently once they were established in their own homes. This often helped them realize the freedom and independence family home care has, which is a healthy balance to feelings of isolation.

Trainees as "Graduates"

Threading throughout the two-month training was discussion of planning for establishing coordination linkages that trainees would have with the demonstration Project as satellite settings. Few linkages were imposed on them as we wished to pursue with them what they considered to be most crucial. Naturally, they would be expected to participate in our overall evaluation research procedures. But, many other coordination variables in such a comprehensive Center could only be articulated by our mothers themselves as they anticipated "moving back" into the periphery.

We found the group enthusiastically planning for procedures to avoid the common pitfalls and shortcomings of FHC as training came to a conclusion and members began leaving the group. They set up a system of substituting for one another in case of illness, to take common field trips and to visit the Child Care Center for experiences with our other children and with male child care workers and equipment that their homes did not provide.

Our "graduates" have been in practice for too short a time to draw any firm conclusions regarding their need for individual and group consultation. The machinations of licensure require individual consultation and seem to preoccupy attention during the early stabilization period. Concerns for finding children to care for have been in part ameliorated by parents' utilizing the Counseling-Coordination Office's referral and placement assistance process.

Our trainees began their work with a feeling of status and importance very much in evidence. Their enthusiasm to get programs in their homes "right away" is somewhat tempered by start-up realities. But monitoring what contributes to enthusiasm, stability and growth is what our satellite demonstration is in part all about.

Status of our Family Home Care Program

At present, we have four satellite homes which we developed through recruitment of "our own" Family Day Care mothers. We are in the process of adding to this cluster of homes from our recruited day care homes (seventeen) that were already in existence in the Medical Center area. In deciding specifically which of these homes will be our satellites, we are accepting applications and working on a contract system.

The contract lists expectations for satellite homes and for the Child Care Project. The Project has agreed to:

1. Provide on-going consultation and workshops.
2. Refer parent consumers from our CCO as appropriate.
3. Loan toys and materials.
4. Assist consumer families to obtain special services when needed.
5. Invite satellite homes to participate in In-Center activities when appropriate and possible to arrange.
6. Provide forms and assistance for Project data collection.
7. Be available for consultation in person and by telephone.
8. Provide these services free of charge.

In return, the Family Home Care Provider agrees to:

1. Maintain a Family Day Care home or provide child care in a consumer's home.
2. Notify our CCO in case of a vacancy and give first priority to referral from that Office.
3. Collect data on children and families as requested.
4. Attend workshops and seminars, provided arrangements can be made for alternate child care, transportation, etc.
5. Notify our CCO of any change in their status.
6. Allow other Project staff to enter their home and do developmental evaluations of children, provided parental consent has been obtained.

We have found that this contract serves to clarify roles and obligations for both the Project and satellite Family Home Care providers.

Same Family Home Care providers in the immediate vicinity have chosen thus far to involve themselves with us to a more limited degree by contacting us for referrals, by consulting with us about toys and equipment or borrowing reading materials. We hope that, over time, they will choose to deepen their relationship with us to enable us to offer to them our full range of supportive services.

As to further training activities of Family Home Care workers, Project staff decided to discontinue the full-time, two-month, stipended training. This decision was based on the fact that the recruitment and training of women "from scratch" was not the most cost-effective way to establish our demonstration satellite homes in view of the readiness of those already in business to conjoin with us. However, the demonstration Child Care Center does have

knowledgeability and practicum capacity for fine training and its utilization can be maximized, we feel, by going a different route, i.e.,

1. Workshops and seminar format for FHC mothers already "in business" throughout Denver.
2. Contracting practicum space and time with other child care educational programs in the metro-Denver area (e.g., Metro State College and Community College of Denver).

We feel this redirection will continue to meet our own satellite mothers' needs for on-going education and will also broaden our dissemination base by opening educational opportunities to the metro-Denver area.

C. THE SCHOOL-AGE CHILD MODEL

As a further component of demonstration of the development of a coordinated, comprehensive child care system, a commitment existed from the outset to explore the need for and feasibility of providing child care for school-age children (6-12 years) in a variety of settings. This is viewed as a logical and appropriate extension of the In-Center and Family Home Care programs and has, to date, assumed two basic thrusts:

a) a summer day camp program and

b) an after school program

The summer day camp. This program was operational from June 13 through August 17, 1973, and served twenty-seven children who ranged in age from five and one-half to nine and one-half (with mean age being seven and one-half). While thirty children were originally enrolled, two did not ever appear and one dropped out after the first day due to no age mates (CA 12) being in the program.

Of the twenty-seven participants, 14.8% of these children had siblings who were enrolled in our In-Center Program. The majority of parents indicated viewing the summer day camp as providing a means for meeting their day care needs (as grossly similar to attitudes pertaining to the In-Center Program). Only two parents perceived the day camp as a "luxury"; one reported a view of it as being both a necessity and a luxury.

The program operated on a five-day-week basis from 7:30 a.m. until 6:00 p.m. While some organized activities were ongoing throughout the course of any given day, unstructured group endeavors were also a part of the program. Crafts activities and field trips were involved. Parents provided transportation to and from the program with length of time in the program daily therefore being somewhat variable for different children.

Observationally, participants can be characterized as being a high energy group with a preference for gross motor, outdoor type activities (versus fine motor, arts and crafts endeavors). Beyond that, the only additional impression of participants was that children in the age range of CA 7-9 seemed to be most cohesive in terms of response to group activities.

While the summer program was open to both UCMC and community-at-large consumers, 60% of ultimate parent consumers proved to be directly UCMC-affiliated. Needs for more advance advertising and provision for greater parental involvement were retrospectively recognized.

Considerable interrelationships developed between the summer day camp and the Project's In-Center Program in terms of sharing of equipment and materials and exchange of ideas relative to management of behavior problems. Additionally, personnel from the In-Center Program provided direct staff support assistance as needs for such occurred.

The after-school program. An after-school program is just at the stage of beginning implementated. Ten children are presently being served from 3:00 to 6:00 p.m., Monday through Friday, at the site of the Project's In-Center Program. All participants are children who have continued on from the summer day camp program.

At this time, the after-school program is focused on gross motor activities of a "play and relax" orientation. However, should parents request that this time be used for more formal educational purposes (e.g., tutorial help or "study hall" type activities), provision to include such activities has been made.

Discussion. The school-age programs have, to date, been more time-consuming (i.e., personal investment "pay-off" in terms of what was actually been realized) than any other single component of the Project model as addressed thus far. Subjectively, this phenomenon seems to derive from the issue of how to sensitize parents to the needs of children of school-age to programs of the nature we are offering.

From a historical perspective, the following has ensued:

Initial explorations indicated the possibility of conjoining the Project's School-Age Child Program with a public school building in the immediate Medical Center area. Project staff initiated contact with this public school in November, 1972. The idea was extremely well-received by both the principal and the school's parents and tentatively planned was the summer day camp to be followed by the after-school program for September, 1973. It was projected that children from both the public school and UCMC would attend.

Out of established protocol, we were required to negotiate with public school upper-echelon administrators for final approval. Throughout these discussions, we received inconsistent feedback as to how well the idea was being received from public school administration as they seemed undecided regarding new programming that would involve themselves in "child care". During this time, we distributed a need survey (Appendix X) for our own program development information purposes and for insuring gathering of parental feedback information which might positively influence public school administrators.

This survey involved the following:

In March, 1973, 4,300 questionnaires were sent to Medical Center students and employees; 155 to public school parents in the immediate Medical Center area. Of the UCMC questionnaires, 147 were returned; 50 public school questionnaires were returned. The lower percentage return on the part of UCMC parents seemingly can be explained when one considers that all public school parents who received the questionnaire had age-eligible school children while we had no way of knowing which or how many of the 4,300 questionnaires would reach Medical Center parents with age-eligible children. Out of all returns, a total number of sixty-two families indicated an interest in a summer day camp program (and, of these, thirty-six were families with UCMC children; twenty-six were public school families).

Project staff reported these results to public school administrators but a delay ensued in finalizing decisions due to illness of a public school administrator. As the summer rapidly approached, we initiated negotiations with a parochial school since we could no longer wait for a definitive answer from the public school system. Committed to community involvement, this parochial school made their building available gratis. We then advertised the summer day camp program as available to public school parents, to parochial school parents, to UCMC parents and to the community at large.

Despite the large number of potential enrollees indicated from the need survey, as well as from follow-up advertising, we placed only twenty-seven families in the program. As we found in having the model In-Center Program readily available, this was a further example of having a program delineated in advance of consumer's needs so that placement, if appropriate, could be expeditious. Actual response, in both instances, proved to be considerably below survey-indicated potential.

It is interesting to note that the summer day camp program, which is almost totally parent-subsidized, is budgetarially "in the black." This is evidently attributable to the following factors:

a) it was run on a strict "pay-as-you-go" basis with parents paying in advance, and

b) space for the program was available on a rent-free basis.

The after-school program, which has continued on as emergent population-wise from the summer day camp program, is in the process of exploring possibilities of conjoining with Family Home Care Services. While this development was not one that was originally conceptualized, it <u>is</u> highly consonant with our satellite-systems orientation and with our process approach.

CHAPTER IV: ADVISORY BOARD

The Advisory Board was conceived out of the commitment of the original planners of the Project to maintain ongoing consumer input into development of the child care delivery system model. We also believed that an interdisciplinary group of professionals had a large stake in quality child care and its coordinative delivery of service from the standpoint of the knowledge they could contribute to blend with that of parents. Further, we felt that increased knowledge about the process nature and value of an advisory board could be derived from formal study of its function over time.

Our Advisory Board is a standing committee comprised of fifteen members: seven "parent representatives" (parents of the children in the demonstration model Child Care Center programs), two "student representatives" (students at the UCMC who may or may not be consumers of services, but are parents), and six "service representatives" (from a variety of professional disciplines of the UCMC faculty and staff). The exact process by which a Board member becomes selected has been vague from the onset. Original members were those who had been participants in the pre-grant planning committee; subsequent membership has been derived from "being asked". As Brieland (1971)[1] describes in his review of community Advisory Boards, a person is likely to end up on a Board because he is available and responsive.

The Board has operated under a co-chairman structure (one service representative and one consumer representative) until the recent departure of the consumer co-chairman to another state. As of June 1, 1973, the typical Board member had served nine months or more. Some member of the Project staff attends most meetings as dependent primarily on agenda issues at hand and need for direct Project staff input.

Sub-committees are not standing but are utilized heavily in dealing with issues which require further study and discussion than is feasible in the context of regular Board meetings. Meetings of the Board began July 5, 1972.

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[1] Brieland, Donald. Community Advisory Boards and Maximum Feasible Participation. American Journal of Public Health, Vol. 61, No. 2, February, 1971, pp. 292-296.

Hence, this became the first subsystem of the demonstration system to be developed. Until October, 1972, weekly meetings were held because of the press for model development; bi-monthly meetings ensued and were subsequently replaced by monthly meetings in February, 1973.

The general purposes of the Advisory Board are: a) to advise Project staff on policy and operations of the Project, b) to inform Project staff of parental concerns and desires, and c) to provide Project staff with professional advice in the areas of psychological, social, educational and medical services. Naturally, if the Board was to live up to the above expectations, considerable input was required from Project staff about Project parameters and goals if feedback from the Board was to be meaningful and relevant.

Initial input to new Board members occurred with their review of the grant proposal. However, ongoing re-orientation and informing took place throughout the Year. For example, content analysis of Board/Project staff interaction from July, 1972, through April, 1973, (involving eighteen meetings), shows that of 210 "give and take" interactions, ninety-eight (47%) of these represented further informational feed-in to the Board by Project staff. Eighteen percent (18%) of the informational feed-in by Project staff pertained to Project goals and progress with 27% of feed-in pertaining to further articulation of program planning as outlined in the grant proposal.

Several studies evaluating the Board were conducted over the year by the Project's Outside Evaluation Team and the Project Director; results of these studies follow.

How We Got Along

The first study in October, 1972, was requested of the Outside Evaluation Team by the Project Director because of perceived problems in group dynamics and role definition of the Board vis-a-vis the Project and its staff. In the beginning months of Project development, we were desperately wanting input from the Board and participation regarding day-to-day problems in getting the 'Project as written' on the road. The parents on the Board seemed: 1) to desire more power and freedom to change Project priorities and 2) to focus on utilization issues concerning the In-Center Program of the Child Care Center model. These problems seemed to produce a polarization within the Board with

parent representatives on one side and service representatives and Project staff on the other. Exchanges between the factions seemed defensive and threatened to become openly hostile and antagonistic. At this point, we contracted with the Outside Evaluation Team to study the workings of the Board and to make recommendations to the staff and the Board. Although the details of the evaluation were planned and the evaluation itself was executed by the external team, it served, at the request of the Project staff, for purposes identified by them; hence, the activity is classified as internal (versus external) evaluation.

The methods employed were as follows: Outside Evaluation Team Observers A and B attended three Advisory Board meetings during October and November, 1972. Observer A was briefed for one day on the history of the Board; Observer B was purposely kept naive. Two observers were used to establish observer reliability. A resultant report with observations and recommendations was submitted to Project staff on November 20, 1972.

A second series of observations was made in April and May, 1973. At this latter date, Observer A was employed again along with a new Observer (C) - both intended to check on observer reliability and to provide a fresh perspective.

The Fall, 1972, evaluation of the Advisory Board resulted in a number of recommendations. The principal recommendations of the report were as follows:

1. That procedures be established to increase the probability of meaningful involvement on the part of the parent representatives and the technical service representatives on the Advisory Board and to decrease Project staff dominance.
2. That consideration be given to utilization of technical service representatives on an ad hoc basis and that their attendance at Advisory Board meetings be made optional.
3. That Advisory Board should be encouraged to pass motions of an advisory nature so that discussions of "old issues" do not drag on interminably.
4. That meeting times and format of the Advisory Board should be examined closely with an eye toward possible changes.
5. That attempts should be continually made to keep communication at Advisory Board meetings direct, open, concise and to the point.
6. That the Advisory Board should establish a procedure by which it might monitor and evaluate its own proceedings.

The principal findings below with respect to each of the six previous recommendations were summarized by the Outside Evaluation Team in May, 1973:

1. The Project staff appears to have made a conscious and sincere effort to "lower its profile" on the Advisory Board. More "inputs" for new business are sought from the Board members and a feeling of democratic participation by Board members is in evidence.
2. Service representatives continue as standing members of the Advisory Board even though their professional expertise appears to be underutilized. In view of their perceptions of the role of the Board and of the Project, their continued participation on the Board seems to preserve a needed balance; if they are not concerned with the underutilization of their professional expertise, neither should anyone else be and their continued service on the Board should be gratefully received.
3. The Advisory Board has still not formulated all of the organizational forms necessary to insure the expeditious conduct of its business but experimentation and exploration in this regard continues. The creation of a sub-committee structure has provided some facilitation of management of concerns.
4. Arrangements for meetings of the Board seem quite satisfactory as evidenced by Board members' responses to a mailed questionnaire.
5. Communications among Board members and Project staff seem noticeably improved over what they were in the Fall of 1972. Exchanges are characterized as more concise and less hostile and defensive.
6. Although the Advisory Board has not established a permanent capability for evaluation of its own workings, it is clear from this report that its operations have been carefully scrutinized and, indeed, have been affected by internal evaluation.

What We Interacted About

In May, 1972, the Project Director carried out a second internal evaluation study of the Board. A rudimentary content analysis of notes was conducted on the eighteen Board meetings from its first meeting in July, 1972, through the April, 1973, monthly meeting. Being committed to "community participation" in decision-making within the Project and also to exploring the nature of feed-in when consumers and professionals come together, we wanted to find out just where discussion and decision emphasis had been. Further, because the Board had appeared to be very verbal and frequent complaints were heard that "we never make a decision", it was desirable to find out just how many critical decisions the Board had made and to determine in what categories most of these occurred.

In analyzing Board meeting notes, eight clearly distinct categories were delineated with respect to content focus; further, each item was rated as to its action capacity (e.g., discussion between Project staff and Board or between Board and Board being termed "Interaction" with decisions made by the Board being termed "Action".) Raw data as to the directionality of Interaction items and Action items as categorized into content areas is presented in Appendix XI. Table XII shows the pooled Interaction items and Action items as they fell into content areas giving a picture of overall focus of Board concern.

TABLE XII.

Analysis of Board Focus by Interaction (Feed-in and Feedback) and Goal-Directed Action (Decision)

Content and Areas	Interaction Items	Action Items	Total Focus	% of Focus
1. Board Process Issues	48	27	75	25
a. Function	27	12	49	
b. Membership	10	8	18	
c. Structure	1	7	8	
2. Service Program Quality Issues	45	30	75	25
3. Consumer Utilization of Demonstration Model	41	18	59	20
4. Budget and Consumer Fees	30	11	41	14
5. Project Goals and Progress	25	0	25	8
6. Personnel Issues	10	0	10	3
7. Facilities and Equip.	9	1	10	3
8. Dissemination	2	4	6	2
TOTALS:	210	91	301	100

Table XIII shows a somewhat sharper picture of the nature of Board decisions.

TABLE XIII

Content Analysis of Advisory Board Decisions
July, 1972--April, 1973

Content of Decisions	Number of Decisions	Percent
1. Consumer Utilization of Demonstration Model	30	33
2. Service Program Quality Issues	27	30
3. Board Membership, Structure and Function	18	20
4. Budget and Consumer Fees	11	12
5. Dissemination	4	4
6. Facilities and Equipment	1	1
7. Project Goals[1] and Progress	0	0
8. Personnel Issues[1]	0	0
TOTALS:	91	100

Viewing our experience with the Advisory Board from this kind of data base has left us with the feeling that the Board 1) has been productive in the decision-making process and 2) has given us fairly clear indication of where, at least in a start-up year, their emphasis has been. For example, it has been useful for us to relate that the Board made ninety-one decisions, sixty-four of these being ones which directly affected Project development in areas in which Project staff were the implementers.

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[1]Content categories: "Project Goals" and "Personnel Issues" contained discussion interaction elements but no decisions. This is presumed to be because of the unchangeable parameters of the grant proposal and personnel policies as stated by the University system under which staff are employed.

Twenty-seven Board decisions (30%) directly affected their own development as an organization. Looking at the Interaction items pooled with Action items in the content area of Board Process Issues, we find a 25% focus of Board time spent on their own organization, purpose and membership. While these data suggest that our Advisory Board has had needs to "get it together" organizationally, these needs in a start-up year have certainly not superseded Board purpose in providing valuable input into the overall Project development. For example, while 25% of the overall Board focus was on its organizational needs, 59% of the discussion focus was on aspects of the Project that would directly affect the consumer and their needs around program quality, utilization and fees. Comparably, 65% of the decisions which the Board made directly affected these three areas.

Another index of the productiveness of the Board is suggested by review of the raw data (Appendix XII) which shows that seventeen items were raised by Project staff about which they desired feedback from the Board (i.e., four items about Board process and thirteen items about other aspects of Project development). However, in response, the Board provided thirty-eight different items of feedback for discussion and ninety-one decisions for a total of 129 "bits" of feedback to staff for their utilization. We might say that the Project staff often got more than they bargained for suggesting that the nature of the Board is both assertive, creative and quite capable of weathering the early evident group dynamic crisis.

What is also clear from the content analysis data is the preoccupation of the Board with the In-Center service component of the Child Care Center model. Discussion items regarding overall Project goals represent only 8% of Board time. Several factors would seem to effect this phenomena: 1) parent representatives this first year were primarily consumers of the In-Center Program, and 2) consumers of the Counseling-Coordination Office only (including those who placed their children in existing community resources) have had difficulty being perceived or perceiving themselves as consumers of the total child care system model as the grant proposal delineated.

We continue to feel that it is important that Board members have the feeling that they "matter" in the decision-making process and that this kind of internal evaluation approach seems to be helpful in providing more concrete data than a feeling state and/or verbal acknowledgment. Such data would seem

to be helpful in any Board's attempt to evaluate its own internal organizational needs in striving to be even more effective in overall decision-making for a program as a whole.

How We Perceived Ourselves

As a part of the Project's outside evaluation of its first Project year, our Outside Evaluation Team explored the question of objectives of the Advisory Board as posed directly to its members through a mail survey. In May, 1973, Advisory Board members were asked to review and rank item lists of main objectives for Advisory Boards as to how important each item was felt to be. These rankings were compared with mean ranks of selected Project staff (i.e., the Project Director, the Director of Program Development, Systems Evaluation Director). Table XIV reflects mean ranks of the Advisory Board as compared with those of the three specified Project staff.

TABLE XIV

Advisory Board Mean Ranks			Main Objectives	Project Staff Mean Ranks Combined
Parents	Serv. Reps.	Combined		
1.25	3.75	2.50	To develop procedures, techniques, and settings for providing quality child-care.	3.33
2.25	2.25	2.25	To demonstrate an effective, total approach to child-care for possible use elsewhere.	1.00
4.25	5.00	4.62	To provide a range of child-care services for the employees of the University of Colorado Medical Center.	5.33
4.50	4.25	4.37	To conduct research on effective child-care procedures.	4.67
4.50	3.25	3.87	To disseminate information about effective child-care procedures.	3.67
4.25	2.50	3.37	To develop an effective counseling procedure for matching needs of parents and their children with an appropriate child-care facility.	3.00

The Outside Evaluation Team's interpretation[1] of these data was as follows:

> The coefficient of concordance for the eight Advisory Board members' rankings was only .271, indicating substantial discrepancies in how various persons perceived the goals of the Project on which they are advising. Generally, the service representatives view the Project more in accord with the Project's own expressed goals, viz., development, refinement, and dissemination of a generalizable child-care model. Understandably, the parents show relatively greater concern for the service function of the Project, though we hasten to add that they nonetheless view the Project first and foremost as a developmental activity. Particularly noteworthy, however, is the low priority given by the parents on the Advisory Board to the objective, "To develop an effective counseling procedure for matching needs of parents and their children with an appropriate child-care facility." An integral component (viz., the Counseling-Coordination Office and its operations) of the model appears not to be receiving the attention it deserves from the parents on the Advisory Board.
>
> The perceptions of the Project's objectives held by the Project staff agree fairly highly with the perceptions of the Advisory Board members. Indeed, the mean rankings of these two groups come out in nearly identical orders. Differences in mean rankings are attributable primarily to the staff seeing the Project first and foremost as a demonstration activity while the Board gave more emphasis to development.

Certainly, the content analysis of the Board speaks to their emphasis on program development as well. The only difference in the above mean rankings is, perhaps as it should be, in terms of Project staff's responsibility in ensuring that demonstration activity be held in its proper perspective.

Several questions in the Outside Evaluation survey instrument dealt with the efficiency, appropriateness and democratic operation of the Board. These data were of particular interest to the Project staff as the content analysis data suggested a more efficient and productive Board than it was feared we might have back in October of 1972. In responses of the Board members as to length, frequency and timing of meetings, no difficulty was perceived, although service representatives appear to feel underutilized and indicate they would not object to less frequent meetings.

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[1] Goodwin, William, Glass, Gene et al. Incremental Summative Evaluation of the Comprehensive Coordinated Child Care Project, Laboratory of Educational Research, University of Colorado, Boulder, June, 1973, p. 74.

All but one respondent felt that the Project staff's practice of meeting with the Board was advisable. In terms of representation of interests on the Board, three of eight respondents felt there should be more parent-consumers on the Board (none felt there should be fewer); two of the eight felt that there should be fewer professional representatives on the Board (and none felt that there should be more.)

The Project staff's own internal opinion of the Board as being productive, assertive and useful was supported further by the six of the eight respondents considering that their participation both at meetings and "outside" was "moderately to extremely active". None of the eight respondents felt that the functioning of the Board had been "ineffective and unimportant for the Project effort."

Dollars Cost of Board Input

Cost accounting of adding consumer and professional representation to the decision-making process was difficult for the Project staff and the Outside Evaluation Team to determine. Board personnel consists of members which have served with no pay and their secretarial services are provided by the secretary of the Counseling-Coordination Office. Secretarial time has been estimated at approximately ten hours per month. Project staff time is presently approximately ten hours per month although, in the early months, there were meetings held weekly instead of monthly. Time of the Project Director alone in interacting with the Board exceeded that. The cost of evaluating the Advisory Board, combining external and internal costs, accordingly, amounted to approximately $1,000 during the past year.

Where We Are Now

The Board now functions on a scheduled monthly basis with an active ad hoc sub-committee system which is presently under review by them. Written communications between Project staff and the Board are increasingly relied upon between meetings to keep the Board "filled in" on Project progress on transactions between subsystems of the model, and on any redirections forthcoming from overall Project re-evaluation. Pressing issues which require immediate action from the Board in assisting the staff in new program

development have diminished due to basic stability of the entire demonstration model. A sense of consonant timing between the Board and the staff has evolved through just plain "living together" but this has more recently been facilitated by Project staff giving the Board more lead time in considering issues and providing specification of a definite time by which feedback is desired - an anticipatory structure that was difficult for staff in the start-up year when everything seemed to happen at once.

Mutual Expectations of Project Staff and Advisory Board for Year II

At completion of review of evaluation feedback about Advisory Board/Project staff interaction and Board progress, the Project Director and Chairman of the Board submitted "open letters" to each other. They are as follows:

To: Advisory Board
From: Project Director

It is the Project staff's hope that in Year II the Board will be able to implement the following:

1. Shifting goals and focus to include more emphasis on total Project goals.
2. Adding to or replacing parent representatives to achieve a broader representation of consumers of the entire model, e.g., from users of model services other than the In-Center service and users of the Counseling-Coordination Office who have their children placed in community resources.
3. Facilitating the development of a standing parent committee to consider the many pressing operational issues arising from the model Child Care Center about which parent input is so relevant.
4. Assuming a more autonomous stance in self-evaluation of their goals and emphasis of their focus; developing their own internal check systems with respect to skewing of focus in contrast to total reliance on external feedback (e.g., from Outside Evaluation Team or Project staff.)

If Project staff "had it to do over", there is only one structural aspect that we would have written in as a framework: insisting that parent memberships include equal representation of each of the Child Care Center's demonstration subsystems - Counseling-Coordination Services, In-Center Services, Family Home Care Services and School-Age Child Programs. Our hindsight feeling is that group dynamics and democratic process structures would have interacted with this broad representation in such a way as to have prevented over-emphasis on the In-Center Program.

To: Project Staff
From: Board Chairman[1]

Considering that Year I was a start-up year with the need for considerable Board input (like instantly), I have learned that the plan to allow the Board to evolve its own structure and functions in a freely democratic way was less desirable than anticipated. For others planning similar projects, I would recommend more specific guidelines as to Board structure and function. For example, taking what I have learned, if we were writing the Project proposal now, but holding the same frame of reference and expectations of the Board as then, I would specify something like this:

A. The Advisory Board shall consist of no more than eighteen voting members of which six should be Service Representatives and six to twelve to be Parent Representatives.

   1. Service Representatives would be selected by the School or Department as follows:
      a. School of Medicine-Pediatrics
      b. School of Nursing
      c. Dietary Department
      d. Social Service Department
      e. John F. Kennedy Pre-School
      f. Education

   2. Qualifications of Service Representatives
      a. Interest in quality care for children.
      b. Willing to commit needed time for Board and committee meetings and related work for one to two years.
      c. Specific knowledge of area represented, e.g., the Social Service Representative having a working knowledge of community resources providing services for children; the Dietary Representative having a working knowledge of dietary needs and habits of children.

B. Parent Representatives serving the Board shall be self-selected (volunteer) or chosen by parents from parents' group of children using UCMC child care facilities; at least one parent representative from each of the demonstration Child Care programs.

C. Project staff and Project Director Participation

   1. Project staff to have one representative to serve without vote to be selected by Project staff.

   2. That Project Director and Project staff be notified of Board meetings and welcomed to participate in Board meetings.

D. Meetings

   1. All Board meetings shall be open to interested members of the Medical Center community to attend without voice or vote except by invitation.

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[1]Personal communication from Edna Coburn, R.N., M.S.

2. Meetings shall be held as needed but no less than four per year.

E. Functions

1. The Board shall advise regarding:
   a. Program planning
   b. Program utilization
   c. Operational policies regarding program
   d. Evaluation of programs in operation three months, six months, one year
   e. Publicity
   f. Operational policies regarding use of programs for education of professionals
   g. Developing liaison and working relations with related service departments of the Medical Center
   h. Developing liaison and working relations with relevant community resources

CHAPTER V: COMMUNITY INVOLVEMENT - INFORMATION SHARING

A demonstration project seeking to serve as a model that can be replicated elsewhere must be concerned with obtaining knowledge about and skill at integrating itself into the already existent "community". Sensitivity to establishing linkages with other agencies in interrelated ways that are meaningful to all concerned served as our basic orientation framework. Accordingly, our initial ventures into the child care community in Denver had two essential purposes:

1. To establish working relationships with others in the community who had resources which were necessary for the satisfactory completion of our original proposal dimensions and,
2. To make ourselves known as an additional resource, available to other groups in the community for consultation.

Relationships to Meet Our Needs

Historically, we began to establish linkages even before original funding of the demonstration Project. Members of the planning steering committee asked for curb-stone consultation from the Colorado State Department of Social Services, the Midtown Hospital Association, the Metro State College Early Childhood Program and other private child care operators in the Denver area. We also made beginning plans for conjoint programming with Mile High Child Care Association, Community College of Denver and the Junior League. The steering committee members brought with them associations with the Denver Public Schools, the Denver Chapter of NOW, the Ad Hoc Women's Coalition for Day Care, the University of Colorado at Boulder Child Care Planning group, and other local groups.

The most productive relationships in assisting and conjoining with us over time were the Mile High Child Care Association, the State Department of Social Services (concerned with licensure and regulations) and the Educational Professional Development Act Training Program in Day Care. Relationships with other programs naturally died on the vine as we obtained adequate data to ensure relevance of our Project plans; other relationships developed into our evolving into assuming a consultation, technical assistance role.

Relationships to Meet a Community Need

In the growth and development process, we were quite comfortable in acknowledging our own areas of strengths and weaknesses. However, some groups seemed to be less discriminative and accepted us almost instantaneously as "super-experts" - others were more circumspect in their reaction. Nonetheless, we found in our early (and continued) community experience that we had stumbled into a local child care leadership gap.

In order to realistically provide others what we can give (not going beyond our experience base) and to build in protection against our natural inclination to "overextend" our energies, we used a basic technical assistance model for conceptualization of our "giving", consultative role. This kind of consultation model required careful delineation of the roles of both the seeker of consultation resources and ourselves (the resource). Within the most realistic relationship, we felt that the seeker must be able to define what kind of expertise is sought. The resource, on the other hand, must be clearly aware and able to articulate what type of expertise and amount of time they can offer, given the specific situation.

To illustrate some of our experiences in more detail:

1. Within the Colorado University community, we have had a number of opportunities for conjoining and/or sharing our experience with child care. For example, (1) we have been regularly involved with the University of Colorado Medical Center Child Protection Team of Dr. C. Henry Kempe. Around this matter, Dr. Kempe's Team and our Project staff have mutually explored how aspects of comprehensive child care settings can help in the area of the battered child. (2) As part of the John F. Kennedy Child Development Center's EPDA Training Program, Project staff have participated with EPDA fellows in comparing and contrasting phenomenon associated both with pre-school education and/or day care. (3) Project staff have been routinely available to planning personnel on the Boulder campus of the University of Colorado to share our experience around child care as they attempt to implement their own child care programs.

2. Consultation with the Education Commission of the States regarding the Satellite Education System has allowed us to share knowledge around various factors in different settings that might contribute to stability of children within a given setting.

3. The Auraria Complex Project, a planned educational complex as a part of an urban renewal project in the Denver area, early contacted us to request consultation for planning a child care program for student parents. This program would be correlatively utilized as a practicum setting for students in early child development from regional colleges and universities. The Project Director of our demonstration Project was a planning committee member for six months, sharing much of the "nitty-gritty" that had been learned in the planning and early start-up period of our Project. A further bonus of serving in such a capacity is that such planning groups of a broad community nature keep a project ever in touch with what everyone else is currently thinking and doing.

4. A local school has requested consultation on the very basic aspects of establishing a child care program, e.g., licensure, surveying for need, funding sources. We have consulted with them as to investigation of the feasibility issues in their school district, with an eye toward possible conjoint programming with our After-School Program.

5. A large local bank responded to early publicity releases on the Project by requesting consultation in their planning for child care needs of their employees. As of this writing, we have helped them to construct and administer a comprehensive survey (see Appendix XII). We felt this effort to have two benefits for the Project: a) it was a direct application of this demonstration model by a non-governmental organization in the local community and b) the bank was willing to pay a consultation fee into our generated funds account.

6. The Regional Office of the Office of Child Development has contacted us and requested that we be represented along with the Mile High Child Care Association at a meeting to help them clarify the child care situation in the Denver area and to begin work toward a pilot program wherein problems with the governmental systems can be identified more specifically. The ultimate goal of this endeavor is promoting and facilitating the growth of child care resources (in a broad sense, to include delivery of special services, etc.)

7. Lately, we have been contacted by Colorado State Hospital in Pueblo requesting us to help plan and to participate in a two-day conference on the new life and marriage styles and the role of child care in this new change. As of this writing, the conference is planned for early Fall, 1973.

8. The local 4-C Council was still in the organizational phase at the time the Project began. Leadership in this group was somewhat divided between private operators and public agency representatives. The group has been searching for a raison d'etre, a common project to unify the group and give it direction. We have continued to meet with this group regularly but we have declined to be the major coordinative agent in the group since, in our judgment, that would be too monumental a task to accept in view of our limited and already highly utilized staff.

9. To strengthen visibility at the State level, we have chosen to be responsive to participating with the State of Colorado Commission on Children and Youth - the Governor's Office's response to the challenge of the Estes Park White House Conference on Children and Youth. While some of the participation has been non-specific to child care per se (towards which our efforts are directed Project-wise), requests to participate in workshops sponsored by the Commission has allowed us "room" to disseminate our position and early findings.

10. Early in February, we were contacted by Colorado Representative Chuck Howe, who had introduced House Bill 1258. This bill planned to appropriate $800,000 in the State of Colorado for child care. He was at that time searching for consultation for expanding and clarifying the bill, as well as adding more specific provisions for funding and administration. We felt it critical to have the bill represent as wide a cross-section of the community as possible and used some previous contacts of Project staff to suggest a broadly heterogeneous group which elected to call itself the Child Care Coalition. This group included educators, private child care operators, representatives of governmental agencies (both state and local) and representatives of other child care organizations - in short, anyone we could think of who would have a contribution to make to the bill. Project staff spent a total of twenty-two hours in formulating the revision for the bill (much of it in the evening). Seven hours in direct testimony was given by Project staff before the House Committee on Health, Education and Welfare and Institutions, the House Appropriations Committee and the Senate Committee on Health, Welfare and Institutions. The revised bill was passed by the Colorado House of Representatives but was postponed indefinitely by the Senate Committee on Health,

Welfare and Institutions until after an interim study could be made this summer. Members of the Project have been asked to testify at that time. For the complete bill, see Appendix XIII.

Other Means of Sharing Information

While our community involvement endeavors have permitted a considerable number and types of opportunities for informal dissemination activities, other modes of sharing information and enhancing our visibility were also pursued. Perhaps most noteworthy was our sponsorhip of a full-day seminar entitled, "The Realities and Fantasies of Industry-Related Child Care."

In selecting a target audience for this first formal dissemination effort, two criteria were utilized:

1. Our own limited experience of less than one year would not allow us to offer deeply detailed or directive information. We could offer assistance in the start-up process and early operational phases only. Thus we had to limit our efforts to those who had had very limited experience in industrial child care programming.
2. Our situation is somewhat unique and in part, could only be generalized validly to other Medical Centers and to other large employers. Our decision to limit this first pilot effort to local groups effectively eliminated the first group and so we turned to local industry.

We offered our findings and experience to local industry via a symposium format. Content was focused on the "business" issues of child care - costs, liability, insurance and licensure regulations. Participants tended to be primarily oriented to issues pertinent to on-site child care centers - with ideas of referral, satellite Family Day Care Homes or coordination of alternative care for ill children being very new to most.

Midco Consultants were among those invited to participate in our symposium. They subsequently requested and received direct consultation from our staff relative to their needs in setting up a series of seminars on Industry and Child Care they were planning in New York, Chicago, Dallas and San Francisco.

Detailed proceedings of the entire symposium are being published under separate cover.

Appendix XIV provides a breakdown of various characteristics of symposium participants.

Visibility of our Project in OCD literature led to our being contacted by various campus representatives (e.g., the University of California at Berkeley, Temple University and the University of Michigan). All such contacts pertained to interest in our model as an exemplary representative of a campus-based project that might yield information pertinent to "start-up" endeavors that were in process at these other institutions.

Additional information sharing has transpired via such avenues as: numerous persons have visited the Project; trainees from diverse disciplines have had various types and amounts of involvement in the Project; flyers, brochures and pamphlet-type publications have been distributed; an article about the Project appeared in the Denver Post and the Medical Center News has reported Project activities on an ongoing basis.

Conclusions

Our community involvement has been broad in nature - extending considerably beyond the confines of our demonstration population community. This has required staff willingness to go "out there" beyond the confines of daily Project program; receptivity to learning how to establish comfortable, rapport-enhancing relationships; ability to monitor commitments to ensure that such endeavors did not detract from needs inherent in ongoing demonstration goals.

We have found that a demonstration project needs to pursue such community involvement during its own planning stages if development is to be realistic and relevant. Feedback from those with whom you share along the way in a project development process becomes highly valuable in determining just where the primary needs are in mastery of a complex, child-effective service delivery system.

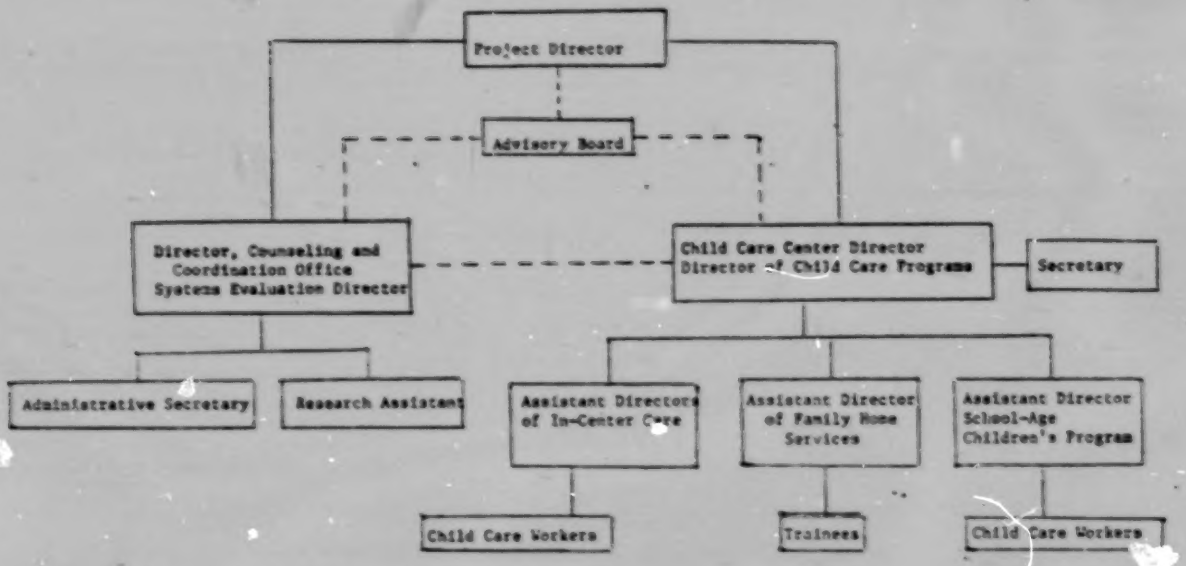
Community involvement endeavors have inherently provided a considerable number of opportunities for informal information-sharing. While our formal dissemination endeavors have not yet been extensive, it has been necessary to let time permit accumulation of more solid and data-based information.

Manpower from all aspects of our community's child care network will continue to be sorely needed to facilitate critical supportive legislation at the state level. As our Project's credibility further increases and our Project data is more solidly based this coming year, we hope we can be of more assistance in the coming state legislative session.

CHAPTER VI: ADMINISTRATIVE FRAMEWORKS AND THE DECISION-MAKING PROCESS

The demonstration project is headed by a part-time Project Director who is employed by the John F. Kennedy Child Development Center on the University of Colorado Medical Center campus. Daily within-Project administration has been the responsibility of two key administrative people, a Director of Child Care Programs and a Director of Systems Evaluation. An administrative flow chart as to responsibility and function for Year I is presented in Figure 6.

Figure 6. OCD Child Care Project Administrative Overview
June 1, 1972

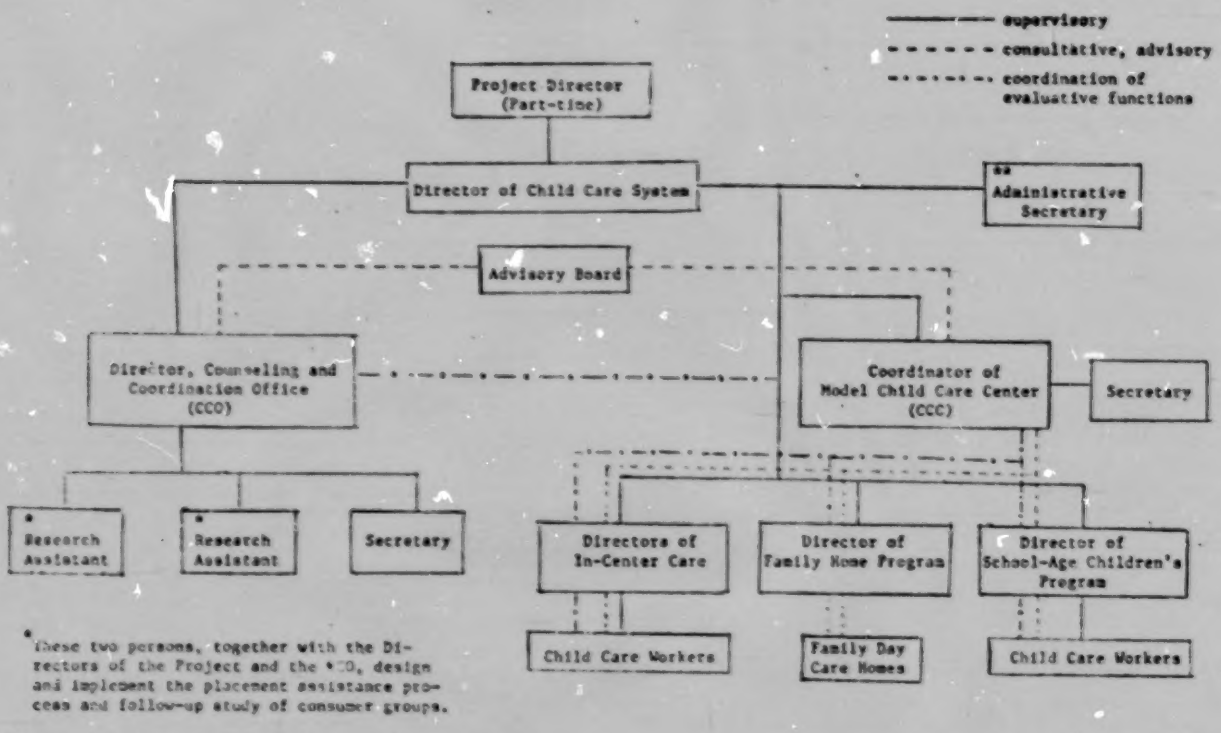


Evaluation of the administrative structure by Project staff strongly suggested that the Project was vulnerable to the "outside" leadership phenomena, i.e., there was no full-time, within-Project boss with whom the buck stopped. Further, our experience with the day-to-day process of working between subsystems

suggested that we needed less directorship activities, but substantially more well-honed coordinative activities. Finally, when our model system was actually in existence, and most of the start-up problems behind us, we found ourselves to be short-handed on the evaluation end of things, particularly if we continued the same administrative framework. Reworking of budget made possible through the termination of the very expensive, time-consuming Family Home Care trainee program, allowed us to strengthen our data-generating, evaluative posture for Year II of the Project. Figure 7 depicts our revised and presently operational administrative overview.

Figure 7. Revised Administrative Overview

July 1, 1973



*These two persons, together with the Directors of the Project and the CCO, design and implement the placement assistance process and follow-up study of consumer groups.

**Handles all fiscal and personnel management and develops secretarial support systems across total Project in keeping with evaluation needs.

Planning and feedback meetings about daily operations occur on a regularly scheduled basis within subsystems. The Director of the Child Care System now meets regularly with each of the persons responsible for the subsystems within the total Project. A weekly meeting is held with the Project Director and the Director of the Child Care System. Further input from the Project Director is obtained through two meetings weekly with Project staff:

1. Program Operations Meeting

   Focus: Feasibility issues in model development as they effect service delivery and evaluation systems.

   Attending: Administrative staff of overall Project and Directors of program subsystems. (Any Project staff other than this may attend if service responsibilities are covered.)

2. Evaluation Operations Meeting

   Focus: Clarification of evaluation design, operational development of evaluation tools, factors influencing data gathering, conferring with outside evaluators.

   Attending: Director of Child Care System, Director of Counseling-Coordination Office, Coordinator of Model Child Care Center, Research Assistants and Administrative Secretary. (Evaluation consultants as necessary.)

Consumer input into the administrative decision-making process was formally designed to occur through the Project's Advisory Board. Informal input from parents occurs at parent discussion groups and individual contacts with parents as they utilize services of the Counseling-Coordination Office or the model Child Care Center.

Conclusions

In a start-up year, specific job descriptions from the onset are naturally a boon to reducing ambiguity for new staff. They also provide the direct extensions of program design which has been planned and give individuals and the project group a sense of initial direction. However, it seems to us that very early a new project staff must be sensitized to the vulnerability of an initial job description to change as the realities of actual implementation begin to signal the needs for shifts in role and responsibility.

A further vulnerability of a new project which includes provision of direct services to a consumer public: the press of meeting consumer needs quickly and at the pace which the public demands can be seductive in letting evaluative dimensions slip. Within the administrative structure of a project which requires

both service and evaluation activity, the structure must provide adequate administrative clout to ensure that an appropriate balance is maintained. Almost compulsive pre-planning with respect to data-gathering instrumentation and role responsibilities is not an automatic safeguard to evaluation slippage. Some procedures do not work as the show gets on the road, either in obtaining the desired data or in lending themselves comfortably to utilization by service delivery personnel. Being able to quickly disregard procedures and functions that are not effective and to harken to immediate feedback experience is a critical administrative function.

Our hindsight view is that we might have acted more promptly in several critical areas. For example, when we first appreciated the heavy service demands on persons primarily responsible for evaluation, we might have reworked job descriptions and/or budget earlier in the year. Or, when we began to sense that CCO consumers using community resources were not spontaneously calling us back for further assistance, we could have instituted routine follow-up sooner.

Why a group does not take action at specific points along the way seems a product of several factors: 1) a need to learn by new experience and a tendency to ruminate as to when there is sufficient data to warrant minor or major program or procedural shifts, and 2) the dynamic character of decision-making persons as individuals or a collective group. Our particular group seemed to have a quality of resistance to "overstructure" during this first year - and an exploratory mode prevailed.

Resistance to "overstructure", however, has helped us to focus on what we really need to meet about and with whom, and has made us aware of the temporal aspects of decision-making. Yet we have found that such resistance can also effect sloppy communication patterns developing early and valuable feedback data (which conceivably can effect ongoing system change) stands in high risk of becoming "lost". Most critical to our overall administrative process changes and the "cleaning up" of our communication systems was the impact of our Outside Evaluation study and our own internal evaluation data. We highly recommend the utilization of such a combination study of an overall system to support major changes. Whereas our Outside Evaluation study report was forthcoming at the end of the Project Year and indeed valuable, we feel that its input value would have been greater had a formal six-month study also been requested.

CHAPTER VII: EVALUATION RESEARCH PLANS FOR YEAR II

At the conclusion of the first Project year, internal and outside evaluation data was reviewed with an OCD site visit team. Trends derived from our first year experience suggested more formal investigation of the placement-assistance process and the factors influencing stability of children in child care settings.

The goals of the Project for the second year are twofold: 1) investigation of variables in the definition, implementation and maintenance of "satisfactory" child care placements and 2) continued documentation of the development of a system of child care service delivery which may be applicable on a broader scale. The first goal is to be approached within a research format; the second goal is again to be approached more anecdotally, with ongoing evaluation feeding back into and modifying the development of the service delivery system. This chapter addresses only the research questions and the plans developed to answer those questions.

The variables which we have elected to study relative to stable and satisfactory child care arrangements fall into two major classes. In one class are factors which each family brings to bear on the child care situation. Such factors as the family's desires and values, potentials for employment or educational opportunities, and family stress factors, among other things, all contribute to special child care needs and influence the outcome of child care arrangements. In the second class are variables which are part of the process of arranging for child care. For example, the availability of a counseling-coordination office (CCO) which offers a variety of child care related services is thought to be a major aid in assisting families in meeting their needs for child care.

A third class of potentially important factors lies in the child care settings themselves, e.g., program offerings, how care-givers relate to children, motives of care-givers for being in business, etc. This Project will not systematically explore all of these factors during this year. For example, one aspect, a subjective quality rating of child care settings, will be investigated as it relates to stability and satisfaction of child care arrangements.

Our sample population will be families where at least one parent is an employee or student at the UCMC. Families become part of the research population by contacting the CCO. For specified groups, data on family characteristics will be obtained by means of a detailed questionnaire. Additional family data will be gathered on some families during in-person interviews.

CCO staff are making site visits to child care settings in the nine zip code areas immediately contiguous to the Medical Center wherein 65% of Medical Center employees live. These visits will increase setting information over that available from Year I survey questionnaires; this setting information will be recorded on Kardex cards as was initiated in Year I (Appendix IV). A subjective quality rating of the setting will be assigned at the time of the visit. Although setting information does not enter the research design as an independent variable, it is an essential part of the match-making process.

Outcome variables will be studied in seven groups differing from each other along the dimension of CCO involvement.

I. Parent placement without CCO involvement.

II. CCO phone referral without setting vacancy search by CCO.

III. CCO phone referral with setting vacancy search by CCO.

IV. CCO matched placement (including vacancy search) with questionnaire and parent interview.

V. CCO matched placement (including vacancy search) with questionnaire, parent interview and extensive post-placement follow-up and intervention.

VI. CCO matched placement (including vacancy search) with questionnaire (same as Group IV, but without interview).

VII. CCO matched placement (including vacancy search) with questionnaire and extensive post-placement follow-up and intervention (same as Group V, but without interview).

Comprehensiveness in coordinating the delivery of special services will be investigated within Groups V and VII. Records of child/family needs above and beyond the need for child care placement (expressed or uncovered during follow-up) and their resolution will be maintained. In addition, care-givers of children in Groups V and VII placed in model service settings will be instructed to bring perceived needs/problems to the attention of the coordinator of the demonstration Child Care Center and records will be kept of the process of their resolution.

Follow-up of all groups will occur relative to stability of the child care arrangement and parents' perception of how satisfactory the arrangement has been both for themselves and their child (Appendix XV). Care-givers providing child care for children in Groups V and VII will be followed relative to their perception of stability, satisfaction and ongoing concerns (Appendix XVI).

Study Groups

Seven major research groups as described above will be generated. Group I, a control group, will be comprised of Medical Center families who have not used CCO services, but who have found child care on their own. These families will be located by inquiring of community resource (CR) settings if they have children of Medical Center families and, if necessary, placing an ad in the Medical Center News asking families who have obtained child care on their own to contact this office to complete a questionnaire (Appendix XVII). The remaining groups will be comprised of families seeking child care by calling the CCO. A request for child care form is shown in Appendix XVIII).

Group II families will be referred to three CR settings on the basis of the age of the child and their expressed desires as to location, setting, times of day when care is needed and cost of services. Referrals to settings will be given over the phone at the time the family first contacts the CCO. The setting information used in making these referrals will be restricted to that available from survey responses to the Year I setting questionnaire plus updated vacancy information if immediately available. Group III families will be treated essentially as Group II families with the following exception: a search for vacancies in known settings will be made prior to recontacting the family by phone within a few days of the initial contact.

Groups IV, V, VI, and VII will be subdivided between community resource and model service facilities. Families placed in both Groups IV and V will be required to complete an extensive questionnaire (Appendix XIX) and participate in an in-person interview prior to setting referrals. CCO staff will contact settings for the parent prior to giving referrals, checking on vacancies, suitability of the setting for the child, updating of cost and times of day factors, etc. When three suitable settings have been located, the families will be informed both by phone and by letter. Group IV families receive no further

intervention from the CCO once placement has been made (unless the family requests CCO assistance). Group V families, however, will be actively followed (Appendix XX), and they and their child care providers will be periodically contacted in an effort to assist the family in satisfying any child care or related needs which may arise during their involvement with the CCO (Appendix XXI). Groups VI and VII will receive the same treatments as Groups IV and V, respectively, except that they will not experience the in-person interview.

Since child care arrangements for each family depend on the age of the child and type of care desired, children in each group will be placed into one of three child care components: child care centers, family home care and school-age programs (which may be located with centers or family homes).

While Model Services (MS) settings will be differentiated from community resource (CR) settings for research purposes, they will not be differentiated in the placement process except as necessary to insure an adequate number of subject families in MS settings. We anticipate an N of 40 in each group, distributed between types of settings and across model services and community resources.

The elegance of this experimental design is somewhat compromised by the ongoing service requirements of the overall Project. Random assignment of families to the various groups is constrained in several respects. (1) Most people who come into the CCO are already familiar with our own Child Care Center and have preconceived ideas regarding the "ideal" placement. (2) It must also be acknowledged that families who call the CCO to initiate the process of finding child care may be different in some ways from families who either do not know of the CCO's existence, or <u>choose</u> not to utilize the CCO for assistance in child care arrangements. Accepting these limiting factors, however, families will be randomly assigned to either the phone referral process (Groups II and III) or the questionnaire process (Groups IV, V, VI and VII) when they first contact the CCO for assistance. In order to keep the number of procedures at a manageable level, placements through December 31, 1973 (or until sufficient number of families have been placed) will be made into Groups II, IV and V. After that time placements will be made into Groups III, VI, and VII.

Placing a family in a research cell will occur only after placement has occurred (Appendix XXII). Families which have completed the questionnaire

will be randomly assigned to Group IV (VI) or Group V (VIII) at the time that placement is confirmed. Groups V and VII families will be made familiar with the special services available to them at that time. Care-givers providing care to Group V and VII families will be notified of available special services following placement confirmation (Appendix XXIII). One-third of the families who have completed the questionnaire will be placed in Group IV (VI) (limited follow-up); two-thirds of the families will be placed in Group V (VII) (extensive follow-up), until all slots within each cell are filled. This is being done in order to generate data regarding the extensive follow-up procedure earlier in the Project year. After all cells are filled, data analysis will be completed on this phase and the system redesigned to incorporate results of the analysis. Subsequent phases in the Project's research design will be determined based on Year II results.

Figure 1 (Appendix XXIV) provides an overview of the procedures used in placing families in research cells, making follow-up calls, and keeping records.

Research Hypotheses

Recurrent throughout many of the research hypotheses are the terms "stable" and "satisfactory". A preliminary definition of "stability" is: the length of time a child care arrangement is maintained. We recognize that in some cases a short duration placement may be very appropriate while some long duration placements may be quite inappropriate. Attempts will be made to adjust the dependent variable of stability along the dimensions of appropriateness.

In part, whether or not an arrangement is "satisfactory" will be determined by asking the family to rate their response to the child care setting (see Final Follow-Up form, Appendix XV). It is anticipated that both definitions will become more fully defined as a result of our second year investigation process.

Operational definitions of terms used in the following hypotheses can be found in Table XV (Appendix XXV).

Research Hypotheses Relating to Families and Children

1. Single-parent families will be more likely to have more stable child care arrangements than two-parent families where both parents are

employed or are students; two-parent families where only one parent is employed outside the home will have the least stable arrangements.

Sample: Groups IV, V, VI, VII

Corollary A.
Children of single-parent families will be more likely to have more stable attendance patterns within the setting than children of two-parent families.

Sample: Groups IV, V, VI, VII

Corollary B.
Children of single-parent families will be less likely to be absent from the child care setting due to illness than children of two-parent families.

Sample: Groups IV, V, VI, VII
(MS only)

Corollary C.
Absence due to illness is predicted to vary from one type of setting to another with children in the Family Home Care Program least likely to be absent due to illness, children in the In-Center Program intermediate and children in the School-Age Child Program most likely to be absent due to illness.

Sample: Groups IV, V, VI, VII
(MS only)

2. When problems with child care arrangements arise, those families which have an extended family member available to fill in or provide regular care will be more likely than others to terminate child care arrangements (i.e., have less stable arrangements over time).

Sample: Groups IV, V, VI, VII

3. Where financial need of the family is the primary motivation for seeking child care, the placement will be more stable over time than where there are other motivations for seeking care.

Sample: Groups IV, V, VI, VII

3. (con't.)

Corollary A.

Where financial need of the family is the primary motivation for seeking child care, the child's attendance patterns within the setting will be more stable than otherwise.

Sample: Groups IV, V, VI, VII
(MS only)

4. The existence of family stress affecting either parent or child will decrease child care stability.

Sample: Groups IV, V, VI, VII

Corollary A.

The existence of family stress affecting either parent or child will decrease stable attendance in the setting.

Sample: Groups IV, V, VI, VII
(MS only)

5. Child care placements for children under two years of age and for two children from the same family within the same setting will be less likely to be obtained than for older and single children. These two variables are expected to interrelate such that for families where both conditions hold, placement will be the most difficult of all.

	No. children together	
Ages	1	2+
2		
2		

Sample: Groups II, III, IV, V, VI, VII
(including all failures)

Corollary A.

Child care placements for children under two years of age and for two children from the same family in the same setting will require more CCO time to obtain than for older and single children.

Sample: Groups II, III, IV, V, VI, VII

5. (con't.)

Corollary B.

Child care placements for children under two years of age and for two children from the same family will require more CCO effort to obtain than for older and single children.

Sample: Groups III, IV, V, VI, VII

Corollary C.

The matching process will be more effective than the non-match process in obtaining placement for families where there is a child under two or when two or more children must be placed in the same setting.

Sample: Groups II, III, IV, V, VI, VII
(including all failures)

6. Women with experience in combining the roles of work and motherhood will require less CCO time to find child care placement than women without this experience.

Motherhood	Work	
	Experienced	New
Experienced		
New		

Sample: Groups IV, V, VI, VII

Corollary A.

Women with experience in combining roles of work and motherhood will require less effort in finding child care arrangements than women without this experience.

Sample: Groups IV, V, VI, VII

Corollary B.

Women with experience in combining the roles of work and motherhood will find greater stability of the child care arrangements than women without this experience.

Sample: Groups IV, V, VI, VII

Research Hypotheses Relating to the Setting

7. There will be a positive relationship between the quality of the setting and the stability of the child care arrangement.

   Sample: Groups IV, V, VI, VII

   Corollary A.
   There will be a positive relationship between the quality of the setting and a satisfactory child care arrangement.

   Sample: Groups IV, V, VI, VII

   Corollary B.
   The higher the rating assigned to a setting, the more frequently will that setting call upon the CCO for coordinated delivery of services.

   Sample: Groups V, VII

Research Hypotheses Relating to Process

8. The more extensive the families' involvement in the CCO process, the more satisfied they will be with the placement process.

   Sample: Groups I, II, III, IV, V, VI, VII

9. The more extensive the families' involvement in the CCO process, the more likely parents will find the child care arrangements to be satisfactory.

   Sample: Groups I, II, III, IV, V, VI, VII

   Corollary A.
   The more extensive the families' involvement in the CCO process, the more stable the child care arrangements will be.

   Sample: Groups I, II, III, IV, V, VI, VII

10. The more extensive the involvement of the CCO in the placement process, the more likely it is that placement will occur.

    Sample: Groups II, III, IV, V, VI, VII
    (including all failures)

11. The more information available about the setting, the greater the success in obtaining placement.

Sample: Groups II, III, IV, VI, VI, VII (CR only)

12. In-person interviews with the parent increases the likelihood that placement will occur, the parent will be more satisfied with the child care arrangement and the relationship will be more stable.

Sample: Groups IV, V, VI, VII

Corollary A.
Interviewed families will be less satisfied with the CCO process as a part of making arrangements.

Sample: Groups IV, V, VI, VII

Corollary B.
More problems will be identified among families who have been interviewed.

Sample: Groups V, VII

13. Phone referral families who must search for vacancies themselves will be less satisfied with CCO assistance than phone referral families who receive referrals after a CCO vacancy search.

Sample: Groups II, III

14. Involvement in the CCO process will increase parent consumers' knowledgeability regarding child care issues.

Sample: Groups II, III, IV, V, VI, VII

Corollary A.
Parents who experience a program of extensive follow-up and intervention will show a greater increase in knowledgeability than those who do not.

Sample: Groups IV, V, VI, VII

15. When the coordination in the delivery of special services is an integral part of the setting system, a larger number of problems will be

identified per family than when this coordination is assumed by an outside system (e.g., CCO).

Sample: Groups V, VII

Corollary A.
When the coordination in the delivery of special services is a part of the setting system, a greater proportion of the identified problems will be resolved than when this coordination is assumed by an outside system (e.g., CCO).

Sample: Groups V, VII

Corollary B.
When the coordination in the delivery of special services is a part of the setting system, the nature of the problems identified will be different than when this coordination is assumed by an outside system (e.g., CCC).

Sample: Groups V, VII

Issues Relating to Families and Children

1. Has availability of child care influenced parents' ability to accept or maintain employment?
2. Do UCMC employees terminate their employment due to problems related to child care?
3. Is child care a factor spontaneously mentioned by potential employees when considering a position at UCMC?
4. What do parents request when they come to a CCO?
   a. Type of setting.
   b. When needed.
   c. Age of child.
5. Is there a relationship between parents' satisfaction with previous child care arrangements and parents' satisfaction with new child care arrangements?
6. Is developmental testing information useful in the placement process? Does availability of such data have a bearing on where placement is effected?

7. Is health information useful in the placement process? Does availability of such data have a bearing on where placement is effected?
8. Are terminations appropriate or inappropriate vis-a-vis the child's development and adjustment?
9. What needs do families have other than child care?
   a. Are identified needs different in different settings?
   b. How are these needs expressed?
   c. Who identifies the need?
   d. When is the need expressed?
   e. Are there resources available and accessible to meet families' needs?
   f. Who is the primary implementer in the need-meeting process?
   g. How much time and effort is involved in the need-meeting process?
   h. What was the effect of intervention on the child, family, setting?
10. Where do parents prefer child care arrangements?
11. What alternate child care arrangements do parents make when their child becomes ill?
12. On the average, how many different child care arrangements have children had since birth?

Issues Relating to Child Care Settings

1. Why are Family Home Care mothers in the business?
2. Are there differences in types of problems identified among school-age children in Family Home Care settings versus In-Center settings?
3. What is the relationship between the age of the child and parent satisfaction with the setting?

Issues Relating to the Child Care Placement Process

1. When child care resources are checked, how many must be called before three alternatives are found and what are the reasons for settings being unavailable or unable to accept a child or children?
2. Is there a relationship between the type of placement procedure and the amount of time the process involves?
3. Will CCO time vary with the type of setting being sought, i.e., Family Home Care, In-Center, School-Age Program?

4. Is there a relationship between the amount of CCO effort involved in seeking placement and increasing CCO involvement in the placement process and does this vary with the setting?
5. How many times do Group II parents recontact the CCO for an additional list of three referrals?

A top priority for Year III is more systematic investigation of child care setting variables. In addition, we anticipate extending the longitudinal aspects of our stability studies, implementing refinements in our placement and intervention processes, and quantifying emerging dimensions of what is a satisfactory child care arrangement.

APPENDIX I

CHILD CARE SETTING EVALUATION CRITERIA

1. ACCESSIBLE

Minimum to Meet Criterion: Parent perceives the setting as convenient in the process of going to and from work.

Other: Parent perceives the setting as convenient to seeing child during the working or school day.

2. ECONOMICALLY FEASIBLE

Minimum to Meet Criterion: Parent perceives the fees as feasible without depriving family of basic necessities.

Other: Parent perceives fee as feasible even though it means sacrificing basic necessities because:

a) no other alternative,
b) wants the "best for the child."

3. DEPENDABLE

Minimum to Meet Criterion:

a) Parents lose no time from work or school because child care worker unavailable due to illness, emergency, or vacations.

b) Parents do not have to go through complex process to find care-giving replacement.

4. PHYSICAL MILIEU WHICH PROVIDES FOR SAFETY:

Minimum to Meet Criterion:

a) All regulations of the state of Colorado Department of Social Services observably implemented into the structure of the facility.

b) Evidence of formal systems in case of emergency within the structure (e.g., fire).

c) Evidence of a formal system in case of emergency to the child.

d) Evidence of adequate supervision of children in use of equipment in individual and group activities.

e) Evidence of anticipatory actions of care-givers which indicate concern for avoidance of accidents and injury.

5. APPROPRIATE STAFF - CHILD RATIOS

Minimum to Meet Criterion:

a) Evidence that minimum State minimums and Federal recommendations are implemented in daily practice.

b) Evidence that children are not overwhelmed by trainees and volunteers so as to interfere with task orientation and motivation of the child.

6. CHILD DEVELOPMENT EVALUATION SYSTEM

Minimum to Meet Criterion:

a) Physical examination and immunizations required to be completed before enrollment.

b) Evidence of having obtained information from parents as to child's health history, individual achievement in social, cognitive, and self-help skills, and individual needs as perceived by parents.

c) Evidence of on-going assessment and evaluation of child's progress and needs in the areas of physical growth, socialization, emotional adjustment, cognitive and motivational development through:

1) Informal observations and recording, or

2) Use of basic developmental screening procedures.

d) Evidence of formal communication systems by which to enlist more sophisticated (i.e., professional) evaluation procedures if a special concern warrants further attention, e.g., consultation, formal evaluation, etc.

7. CHILD-FAMILY FOCUSED PHILOSOPHY OF CARE GIVING

Minimum to Meet Criterion:

a) Program can speak to a definable process they utilize to facilitate the psychological move from family environment to the new setting.

b) Program has information about the total family and at least one care-giver perceives him/herself as thoroughly knowledgeable of the child-family development and can act as the family advocate should it be necessary in the need meeting process.

c) Formal system established that ensures adequate day-to-day communication between staff and parent relevant to child and family.

d) Milieu reflects evidence of appreciation of family's ethnic cultural differences and values (e.g., pictures, books, displays, special meals, etc.).

e) Attitude of staff reflects a perception of child care which complements rather than supplements family care, while at the same time provides critical experiences for the child which may not be available at home.

f) Formal communication system by which parents may express concerns about childrearing and obtain assistance within the setting program or by referral.

Other: Formal system within the program by which parents can receive education around childrearing and family life issues (e.g., nutrition, preventive health care of children and selves, prenatal care, planned parenthood, problems created by work and school patterns).

Formal system by which parents utilizing a child care setting as a group can participate in overall development of the child care setting.

8. DAY-TO-DAY PROGRAMMING WHICH INTEGRATES THE HEALTH, SOCIAL, EMOTIONAL, COGNITIVE AND MOTIVATIONAL NEEDS OF THE CHILD

Minimum to Meet Criterion:

a) Scheduled meals and snacks which are nutritionally adequate; evidence of allowing additional food as dictated by the child's needs.

b) Scheduled rest periods commensurate with developmental age of the child; evidence of allowing extra rest periods at non-scheduled times when child's needs dictate.

c) Evidence that the setting provides the essential space, play equipment, and self-help conveniences which will maximize development of growth enhancing experiences.

d) Evidence that good physical and emotional care is provided a child should he/she become ill during the day:

1) Special rest facilities separate from the group;

2) Individualized attention lest the child feel isolated and frightened;

3) System by which parents are informed;

4) System by which medical care can be provided readily if needed.

e) Evidence that initial data received from parents and on-going developmental evaluation data feeds back into planned experiences which are maximally suited to child's individual needs.

f) Evidence that staff encourages the child to explore, make choices, allow mistakes and assists the child in developing a variety of coping strategies.

g) Evidence that staff promotes the development and understanding of a variety and balanced expression of emotional feelings.

h) Evidence that staff assists a child to effectively cope with group process, helping the child to maintain his autonomy while learning to share and relate with others.

i) Evidence that staff facilitates the child's motivational and attentional processes through selection of appropriate and stimulating tasks in both one-to-one and small group activities.

j) Evidence that staff is sensitive to the young child's time-to-time needs for tactile as well as verbal reassurance and nurturance.

9. FORMAL SYSTEMS TO PROVIDE CHILD AND FAMILY SPECIALIZED SERVICES

Absolute Minimum to Meet Criterion:

a) Evidence that the setting has comprehensive information resources for referral purposes if specialized health, education, and social services needs of child and/or family are evident.

b) Evidence that the setting staff is willing to assist the family to facilitate a referral.

c) Evidence that, in the case of referral of the child, the setting is willing and able to provide evaluative information about the child.

d) Evidence that any referral plans are made conjointly with parents and with their permission. (Exception: referral of case of suspected child abuse where parental participation is rejected by them.)

Preferable Minimum in Addition to Above:

e) Availability of regularly scheduled professionals representing the various health, education, and social service disciplines on a consultative basis.

f) Availability of professional and paraprofessional services on a regularly scheduled basis to be concerned with formal evaluations as necessary (health, educational, psychological), training of staff, and parent education programs.

g) Evidence of a formal communication and transportation system to facilitate a child's receiving specialized treatment services for health, education, and emotional disorders.

Other:

h) Evidence of a formalized system by which the multi-professional disciplines can participate with parents in the overall planning and development of the child care setting.

UNIVERSITY OF COLORADO MEDICAL CENTER
4200 EAST NINTH AVENUE
DENVER, COLORADO 80220

COMPREHENSIVE CHILD CARE PROJECT
COUNSELING-COORDINATION OFFICE
UCMC BOX #2338
TELEPHONE: 394-8586
CHILD CARE CENTER
UCMC BOX #2311
TELEPHONE: 321-3023

JANE E. CHAPMAN PH.D., PROJECT DIRECTOR
PAUL T. BARNES, PH.D., DIRECTOR
COUNSELING-COORDINATION OFFICE
FERN PORTNOY, M.ED., DIRECTOR
CHILD CARE CENTER

APPENDIX II

HEALTH HISTORY FORMS

Dear Parent and Physician:

The State law in Colorado requires each child considered for application to licensed child care facilities to have a complete physical exam before admission.

We feel that periodic health examinations and on-going health supervision are important for the rapidly developing child. We also feel that it is helpful for child care workers to know the child's health history so special assistance or concern about health issues can be a part of your child's care.

Attached is a two-part Health History and Examination form. The yellow section we are asking parents to fill out before going to the doctor so he or she can review it before the examination. The white section is for the physician to complete. Also attached is: 1) a green permission form which allows a child to be treated for an emergency medical situation should child care workers be unable to contact parents immediately, and 2) a blue medical certification form. Both the green permission form and blue certification is to be taken by you to the child care setting on the first day your child is enrolled. The yellow and white sections are to be mailed to the child care setting by your physician.

We hope this form is helpful in your evaluating a child's and family's present health status.

Thank you.

Sincerely,

Paul Barnes, Ph.D., Director
Counseling-Coordination Office

THE UNIVERSITY OF COLORADO IS AN EQUAL OPPORTUNITY EMPLOYER

UCMC CHILD CARE PROJECT

THIS PORTION TO BE COMPLETED BY PARENTS

HEALTH HISTORY AND EXAMINATION Date_____

Name of Child_____ Birth Date_____

Address_____

Name of Father_____

Name of Mother_____

Legal Guardian of Child_____

Pregnancy (for this child):

Health of mother during pregnancy: Excellent_____ Fair_____ Poor_____
Please describe any problems during pregnancy (such as bleeding, fainting or dizziness, or serious illness, need for medications).

_____

_____

Birth

Was your child born head first? Yes_____ No_____ If no, how was child born?

_____

Did your child breathe immediately after birth? Yes_____ No_____

Any breathing difficulties, jaundice, blood transfusions, or other problems as a newborn in the hospital? Yes_____ No_____ If yes, describe.

_____

Was your child released from hospital with mother? Yes_____ No_____. If no, please give details.

_____

First Weeks after Birth

Did your child have any difficulties these first weeks (such as eating, sleeping, medical problems)? Please describe.

_____

How did mother feel during these first weeks?

_____

How did father feel during these first weeks?

_____

FAMILY HEALTH HISTORY

Please describe the present health of immediate family and other people in your home:

1. _____ : _____
2. _____ : _____
3. _____ : _____
4. _____ : _____
5. _____ : _____
6. _____ : _____
7. _____ : _____

Please indicate if any family member or relative has had any of the following illnesses; give name and date.

ILLNESS	RELATIONSHIP TO CHILD	DATE
Diabetes		
Heart Disease		
Mental retardation		
Cystic fibrosis		
Epilepsy		
Serious emotional problems		
Alcoholism		
Tuberculosis		
Hepatitis		
Parasitic infection such as Hookworms, Pinworms, or Trichnosis.		
Other serious illness requiring medical treatment and/or hospitalization. Please give details.		

Has there been a prolonged separation, divorce, or death among close family members during your child's lifetime? Yes_____ No_____ If yes, please give dates and details.

CHILD'S HISTORY

Please indicate if your child has had, or presently has, any of the following illnesses.

ILLNESS	DATE (S)	DESCRIBE IF NECESSARY
Measles (red or 10-day)		
Measles (3-day or German)		
Mumps		
Chicken pox		
Whooping cough		
Urinary infection		
High fever (describe)		
Convulsions		
Unconsiousness (describe)		
Injury		
Excessive bleeding: Internal		
Excessive bleeding: External		
Accidental poisoning, ingestions (describe)		
Cardiac disease (describe)		
Ear aches and/or infections		
Fall from height		
Other serious illness (specify)		

How many colds has your child had this past year?_____

How many times has your child been seen by a physician this past year?

_____

Has your child ever been hospitalized? Yes_____ No_____ If yes, please give dates and details:

_____

_____

_____

APPENDIX II -- CONTINUED

IMMUNIZATION HISTORY

Please give dates your child received any of the following immunizations:

DPT #1_____ #2_____ #3_____ Booster_____

Polio #1_____ #2_____ #3_____ Booster_____

Tetanus Boosters #1_____ #2_____

3-day Measles (German, Rubella) _____

10-day Measles (Rubeolla) _____

Mumps _____

Smallpox _____

DENTAL HISTORY

Is your child presently under regular care from a dentist? Yes_____ No_____

Does your child need help with carrying out dental hygiene while being cared for in the child care setting? Yes_____ No_____ Explain _____

_____

OTHER

Is there anything concerning your child's health or behavior which particularly concerns you? If so, please describe.

THIS PORTION TO BE COMPLETED BY PHYSICIAN

PHYSICAL EXAMINATION

1. Does the child have any emotional or physical condition which require current professional supervision? Please give details.

What medications does the child presently require?

2. Allergies:

Recommended restrictions:

3. General statement about health of the child's family:

Physical Exam

Head _____

Neck _____

EENT _____

Chest _____

Abdomen _____

Extremities _____

GU _____

Neurological _____

TPR:

Height:

Weight:

Head circumference:

Screening Tests Performed and Results

TEST	DATE	RESULTS
TB skin		
Lead Poisoning		
Sickle Cell Anemia		
Vision		
Hearing		
Denver Developmental Screening Test		

Immunizations given this visit: _____

_____

_____

Recommendations for health follow-up in child care setting: _____

_____

Restrictions on:

Activity _____

Diet _____

Other _____

_____
Signature of Physician

_____
Date

_____
Address

_____
Telephone No.

_____
Hospital Affiliation

MEDICAL STATEMENT

This certifies that _____

was examined on _____, 19____ and is free from abnormalities or illnesses that would make admission to licensed child care facilities undesirable.

Immunization status of this child is in keeping with the current recommendations of the American Academy of Pediatricians.

Signed _____, M.D.

Date _____

Detach and have parents return to child care facility immediately.

EMERGENCY MEDICAL CARE

I agree that in case of accident, injury, or sudden severe illness, emergency care may be given to my child(ren)_____ in the event that I (or my spouse) cannot be contacted immediately.

I understand that every reasonable effort will be made to contact me (or my spouse) should an accident, injury, or sudden severe illness occur.

In the event that hospitalization is required, I give my consent for my child(ren) to be taken to _____(hospital), preferably to be placed under Dr. _____'s care. In the event Dr. _____ can not be located, I give my consent for treatment to be given by a qualified physician. I agree to assume responsibility for the expenses incurred for the care given to my child.

_____
Signature

_____
Date

_____
Witness

_____
Doctor's Name

_____
Address

_____
Telephone no.

Detach and have parent return to child care facility immediately.

APPENDIX III

MILE HIGH CHILD CARE ASSOCIATION

Referral Questionnaire
(Child Care Centers)

Date_____

Center Name_____

Address_____
Street

_____
City County Zip Code

Telephone No._____ Your Name_____
Title

Do you provide transportation? Yes_____ No_____ Nearest Bus Line #_____

My Center is in operation as a: a) Public Agency _____
b) Voluntary Non-Profit Agency _____
c) Private Business _____
d) Franchise _____

What kinds of care do you provide?

a) Full time (5-day). _____ Week-end. _____
Part time. Explain. _____ Evening. _____
Drop-in (Emergency Health Certificate). _____ Before & after school. _____

b) School year only_____ Summer only_____ Full year_____

Number of children you are licensed for:_____ Age range:_____

Are you currently filled? Yes_____ No_____

If not, how many vacancies?_____ For what ages?_____

Hours you provide care:_____

List the activities you provide for the children:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Meals provided: Breakfast____ Lunch____ Dinner _____
Morning Snack_____ Afternoon Snack_____

What is your absence policy if you or staff members are ill or take vacations?

_____
_____

What is your illness policy if a child becomes ill?_____

_____

Do you care for children who are not toilet trained? Yes_____ No_____

Do you care for children who have special problems? Yes_____ No_____

If so, what kind?_____

What types of children with problems are you not interested in accepting? _____

_____

What other admission restrictions do you have?_____

_____

Do you evaluate the child's developmental progress? Yes_____ No_____

How?_____

Do you ever use special consultants or community agencies if a child's behavior concerns you?

Yes_____ No_____ Explain_____

Do you have parent conferences? Yes_____ No_____

Do parents of the children in your Center hold parent meetings? Yes_____ No_____

Do parents of the children in your Center hold parent meetings? Yes_____ No_____

Who pays for your child care services? Parents _____

Public Agency _____

Parent's Employer _____

Other (Specify) _____

What are your charges for the following kinds of care?

Full time	$_____per_____
Part time	$_____per_____
Drop-in	$_____per_____
Week-end	$_____per_____
Evening	$_____per_____
Before & after school	$_____per_____

Do you charge overtime? Yes_____ No_____

How do you charge for parent holidays and vacations?_____

_____

Do you have special rates for more than one child in a family? Yes_____ No_____

Explain_____

Please add anything else you wish us to know about your program.

_____

_____

_____

_____

_____

_____

_____

_____

FOR PUBLIC SPONSORED AND VOLUNTARY NON-PROFIT AGENCIES:

What agency pays for your services?_____

Are you limited by: Area_____ Income_____ Other_____

Please explain_____

_____

_____

_____

MILE HIGH CHILD CARE ASSOCIATION

Referral Questionnaire
(Family Day Care Services)

Date_____

Your Name_____

Address_____
Street

_____
City County Zip Code

Telephone No._____ Nearest Bus Line #_____

What kind of care do you provide?

a) Full time (5-day). _____ Week-end. _____
Part time. Explain. _____ Evening. _____
Drop-in (Emergency Health Certificate). _____ Before & after school. _____

b) School year only_____ Summer only_____ Full year_____

Number of children you are licensed for:_____ Age range:_____

Are you currently filled? Yes_____ No_____

If not, how many vacancies?_____ For what ages?_____

Hours you provide care:_____

List the activities you provide for the children:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Meals provided: Breakfast_____ Lunch_____ Dinner _____

Morning Snack_____ Afternoon Snack_____

Do you have a substitute to care for the children if you are ill or on vacation?

Yes_____ No_____

What is your illness policy if a child becomes ill?_____

_____

Do you speak any other language besides English? Yes_____ No_____

If yes, what language?_____

Do you care for children who are not toilet trained? Yes_____ No_____

Do you care for children who have special problems? Yes_____ No_____

If so, what kind?_____

What types of children with problems are you not interested in accepting?_____

_____

Do any community agencies help you with children who have problems?

Yes_____ No_____

Who pays for your day care services? Parents___ Public Agency___ Parent's Employer___

What are your charges for the following kinds of care:

Full day:	$_____per_____
Half day	$_____per_____
Drop-in	$_____per_____
Week-end	$_____per_____
Evening	$_____per_____
Before & after school	$_____per_____

Do you charge extra for children who are not toilet trained? Yes_____ No_____ $_____

Do you charge overtime? Yes_____ No_____ $_____

How do you charge for parent holidays and vacations? _____

_____

Do you have special rates for more than one child in a family? Yes_____ No_____

Explain_____

Please add anything else you wish us to know about your program or about yourself.

_____

_____

_____

_____

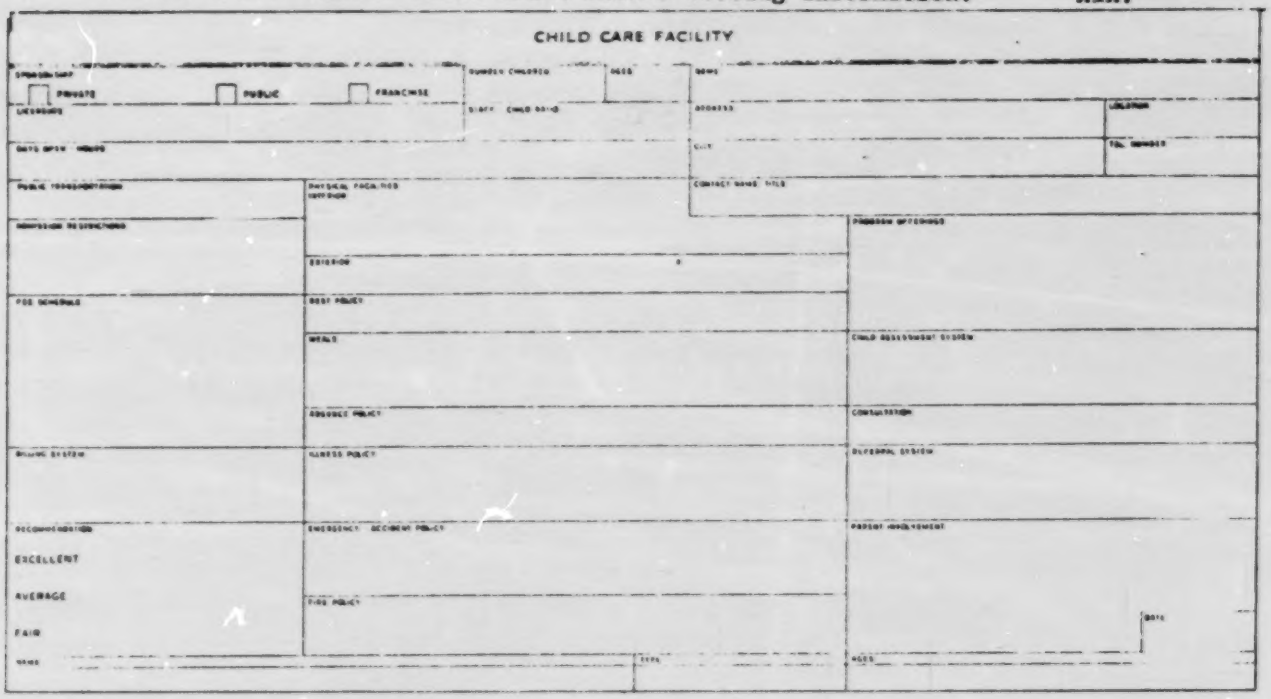
FOR PUBLIC SPONSORED OR VOLUNTARY NON-PROFIT AGENCIES:

What agencies pay for your service? _____

Are you limited by: Area_____ Income_____ Other_____

Please explain_____

_____


CHILD CARE FACILITY

SPONSORSHIP
☐ PRIVATE ☐ PUBLIC ☐ FRANCHISE

LICENSURE

DATE OPEN HOURS

PUBLIC TRANSPORTATION

ADMISSION RESTRICTIONS

FEE SCHEDULE

ACCOMMODATION
EXCELLENT
AVERAGE
FAIR

NUMBER CHILDREN AGES

STAFF CHILD RATIO

PHYSICAL FACILITIES DESCRIPTION

EXPANSION

DIET POLICY

MEALS

ABSENCE POLICY

ILLNESS POLICY

EMERGENCY ACCIDENT POLICY

FIRE POLICY

NAME

ADDRESS

CITY

CONTACT NAME TITLE

PROGRAM OFFERINGS

CHILD ASSESSMENT SYSTEM

CONSULTATION

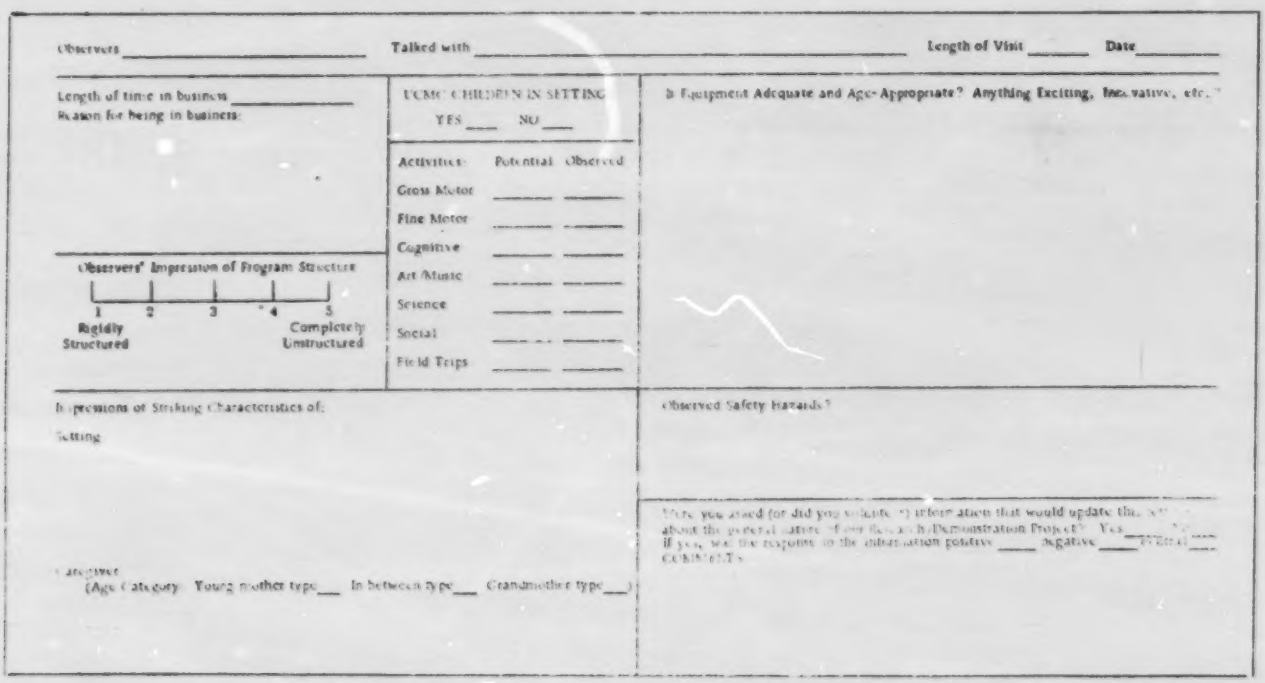
DISCIPLINE SYSTEM

PARENT INVOLVEMENT

DATE

AGES

YEAR I SETTING QUESTIONNAIRE INFORMATION (FRONT OF CARD)


Observers _____ Talked with _____ Length of Visit _____ Date _____

Length of time in business _____
Reason for being in business:

Observers' Impression of Program Structure

1 2 3 4 5
Rigidly Structured — Completely Unstructured

UCMC CHILDREN IN SETTING
YES ___ NO ___

Activities:	Potential	Observed
Gross Motor	___	___
Fine Motor	___	___
Cognitive	___	___
Art/Music	___	___
Science	___	___
Social	___	___
Field Trips	___	___

Is Equipment Adequate and Age-Appropriate? Anything Exciting, Innovative, etc.?

Impressions of Striking Characteristics of:

Setting

Caregiver
(Age Category: Young mother type___ In between type___ Grandmother type___)

Observed Safety Hazards?

Were you asked for did you volunteer any information that would update this [illegible] about the general nature of our Research/Demonstration Project? Yes ___ No ___
If yes, was the response to the information positive ___ negative ___ neutral ___
COMMENTS

YEAR II SETTING SITE VISIT INFORMATION (BACK OF CARD)

APPENDIX V

PARENT CONTACT FORM

NAME OF PARENT(S) _____

_____

CHILD'S NAME _____

WHO INITIATED THE DISCUSSION? ME _____ PARENT _____ PHONE CALL? _____

WHAT WAS DISCUSSED? (include role of parent and/or your role)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

HOW DID PARENT FEEL? Positive _____ Negative _____

Other (please indicate) _____

_____ _____

Your name Date

APPENDIX VI

ILLNESS AND ABSENCE RECORD

Child's name_____ Date_____ Time_____

In-Center Incident_____ Parent phoned Center_____

Type of illness or accident_____

_____

In In-Center incident, was parent contacted? Yes____ No___ Time_____

Who handled incident (phone calls, aid to child)_ _____

Did child leave Center? Yes___ No___ Time_____

With whom did child leave? _____

Physician consulted? Yes_____ No_____ If yes, by whom?_____

Name of physician consulted_____

Physician visited? Yes____ No____ Name_____

Diagnosis_____ Who made_____

Recommendations of Dr:_____

_____

Lab data (if any, e.g., cultures, urine,Hit)_____

_____

Recommendations of parent_____

_____

Type of medication, if any_____

Dosage_____ Duration_____

Child's reaction to illness_____

_____

_____

Alternate child care?_____

How did parent find alternate child care?_____

Did parent lose wages? Yes____ No____ Vacation or Sick Days ?
(circle)

Parent's opinion of how things might have been handled differently to minimize difficulties_____

_____

Anecdotal Comments:_____

_____

_____

_____

_____

_____

Follow-up Activities:_____

_____

_____

Total time child out of Center_____

APPENDIX VII

IN-CENTER EVALUATION, MAY, 1973

QUALITY CARE CRITERIA	DIRECT[1] STAFF A (N = 11) %	INDIRECT[2] STAFF B (N = 6) %	PARENTS (C) (N = 15) %	TOTAL (N = 32) %
I. ACCESSIBLE				
1. Minimum to Meet Criterion: Parent perceives the setting as convenient in the process of going to and from work.	100	83	100	97
2. Other: Parent perceives the setting as convenient to seeing child during the working or school day.	54	67	73	62
II. ECONOMICALLY FEASIBLE				
3. Minimum to Meet Criterion: Parent perceives the fees as feasible without depriving family of basic necessities.	91	67	66	75
4. Other: Parent perceives fee as feasible even though it means sacrificing basic necessities because: (a) no other alternative, (b) wants the "best for the child."	64	33	46	50
II . DEPENDABLE				
Minimum to Meet Criterion: 5. (a) Parents lose no time from work or school because child care worker unavailable due to illness, emergency, or vacations.	91	83	93	91
6. (b) Parents do not have to go through complex process to find care-giving replacement.	73	33	60	59
1.. PHYSICAL MILIEU WHICH PROVIDES FOR SAFETY				
Minimum to Meet Criterion: 7. (a) All regulations of the State of Colorado Department of Social Services observably implemented into the structure of the facility.	73	100	80	81
8, (b) Evidence of formal systems in case of emergency within the structure (e.g., fire).	100	83	87	91

[1,2]Type of involvement with both children and their families in the In-Center Program of the demonstration Child Care Center.

APPENDIX VII -- CONTINUED

CRITERIA	DIRECT STAFF A (N = 11) %	INDIRECT STAFF B (N = 6) %	PARENTS (C) (N = 15) %	TOTAL (N = 32) %
9. (c) Evidence of a formal system in case of emergency to the child.	100	100	73	86
10. (d) Evidence of adequate supervision of children in use of equipment in individual and group activities.	82	67	80	78
11. (e) Evidence of anticipatory action of care-givers which indicate concern for avoidance of accidents and injury.	91	50	87	81
V. APPROPRIATE STAFF-CHILD RATIOS				
Minimum to Meet Criterion:				
12. (a) Evidence that minimum State minimums and Federal recommendations are implemented in daily practice.	82	100	66	78
13. (b) Evidence that children are not overwhelmed by trainees and volunteers so as to interfere with task orientation and motivation of the child.	73	67	93	81
VI. CHILD DEVELOPMENT EVALUATION SYSTEM				
Minimum to Meet Criterion:				
14. (a) Physical examination and immunizations required to be completed before enrollment.	82	83	93	86
15. (b) Evidence of having obtained information from parents as to child's health history, individual achievement in social, cognitive, and self-help skills, and individual needs as perceived by parents.	100	100	93	97
16. (c) Evidence of on-going assessment and evaluation of child's progress and needs in the areas of physical growth, socialization, emotional adjustment, cognitive and motivational development through: (1) Informal observations and recording, or (2) Use of basic developmental screening procedures.	91	83	87	86

APPENDIX VII -- CONTINUED

CRITERIA	DIRECT STAFF A (N = 11) %	INDIRECT STAFF B (N = 6) %	PARENTS(C) (N = 15) %	TOTAL (N = 32) %
17. (d) Evidence of formal communication systems by which to enlist more sophisticated (i.e., professional) evaluation procedures as a special concern warrants further attention, e.g., consultation, formal evaluation, etc.	100	67	87	86
VII. CHILD-FAMILY FOCUSED PHILOSOPHY OF CARE GIVING.				
Minimum to Meet Criterion:				
18. (a) Program can speak to a definable process they utilize to facilitate the psychological move from family environment to the new setting.	73	50	80	72
19. (b) Program has information about the total family and at least one caregiver perceives him/herself as thoroughly knowledgeable of the child-family development and can act as the family advocate should it be necessary in the need meeting process.	91	16	66	65
20. (c) Formal system established that ensures adequate day-to day communication between staff and parent relevant to child and family.	73	33	53	56
21. (d) Milieu reflects evidence of appreciation of family's ethnic, cultural differences and values (e.g., pictures, books, displays, special meals, etc.)	73	83	93	84
22. (e) Attitude of staff reflects a perception of child care which complements rather than supplements family care, while at the same time provides critical experiences for the child which may not be available at home.	82	33	100	81
23. (f) Formal communication system by which parents may express concerns about childrearing and obtain assistance within the setting program or by referral.	91	67	80	81

APPENDIX VII -- CONTINUED

CRITERIA	DIRECT STAFF A (N = 11) %	INDIRECT STAFF B (N = 6) %	PARENTS(C) (N = 15) %	TOTAL (N = 32) %
24. Other: Formal system within the program by which parents can receive education around child-rearing and family life issues (e.g., nutrition, preventive health care of children and selves, prenatal care, planned parenthood, problems created by work and school patterns).	82	33	46	56
25. Formal system by which parents utilizing a child care setting as a group can participate in overall development of the child care setting.	82	83	93	86
VIII. DAY-TO-DAY PROGRAMMING WHICH INTEGRATES THE HEALTH, SOCIAL, EMOTIONAL, COGNITIVE AND MOTIVATIONAL NEEDS OF THE CHILD.				
Minimum to Meet Criterion:				
26. (a) Scheduled meals and snacks which are nutritionally adequate; evidence of allowing additional food as dictated by the child's needs.	91	100	93	94
27. (b) Scheduled rest periods commensurate with developmental age of the child; evidence of allowing extra rest periods at non-scheduled times when child's needs dictate.	100	100	87	94
28. (c) Evidence that the setting provices the essential space, play equipment, and self-help conveniences which will maximize development of growth enhancing experiences.	91	83	93	91
(d) (Evidence that good physical and emotional care is provided a child should he/she become ill during the day:				
29. 1) Special rest facilities separate from the group.	100	100	100	100
30. 2) Individualized attention lest the child feel isolated and frightened.	91	33	87	78

APPENDIX VII — CONTINUED

CRITERIA	DIRECT STAFF A (N = 11) %	INDIRECT STAFF B (N = 6) %	PARENTS (C) (N = 15) %	TOTAL (N = 32) %
31. 3) System by which parents are informed.	100	100	93	97
32. 4) System by which medical care can be provided readily if needed.	100	83	73	84
33. (e) Evidence that initial data received from parents and on-going developmental evaluation data feeds back into planned experiences which are maximally suited to child's individual needs.	91	0	60	59
34. (f) Evidence that staff encourages the child to explore, make choices, allow mistakes and assists the child in developing a variety of coping strategies.	91	33	93	81
35. (g) Evidence that staff promotes the development and understanding of a variety and balanced expression of emotional feelings.	82	33	93	78
36. (h) Evidence that staff assists a child to effectively cope with group process, helping the child to maintain his autonomy while learning to share and relate with others.	91	83	100	94
37. (i) Evidence that staff facilitates the child's motivational and attentional processes through selection o of appropriate and stimulating tasks in both on-to-one and small group activities.	91	16	87	75
38. (j) Evidence that staff is sensitive to the young child's time-to-time needs for tactile as well as verbal reassurance and nurturance.	100	67	87	86
IX. FORMAL SYSTEMS TO PROVIDE CHILD AND FAMILY SPECIALIZED SERVICES.				
Absolute Minimum to Meet Criterion:				
39. (a) Evidence that the setting has comprehensive information resources for referral purposes if specialized health, education, and social services needs of child and/or family are evident.	100	67	87	86

APPENDIX VII -- CONTINUED

CRITERIA	DIRECT STAFF A (N = 11) %	INDIRECT STAFF B (N = 6) %	PARENTS (C) (N = 15) %	TOTAL (N = 32) %
40. (b) Evidence that the setting staff is willing to assist the family to facilitate a referral.	100	83	80	86
41. (c) Evidence that, in the case of referral of the child, the setti is willing and able to provide evaluative information about the child.	100	83	87	91
42. (d) Evidence that any referral plans are made conjointly with parents and with their permission. (Excpetion: referral of case of suspected child abuse where parental participation is rejected by them.)	100	67	80	84
Preferable Minimum in Addition to Above:				
43. (e) Availability of regularly scheduled professionals representing the various health, education, and social service disciplines on a consultative basis.	100	100	80	91
44. (f) Availability of professional and paraprofessional services on a regularly scheduled basis to be concerned with formal evaluation as necessary (health, educational, psychological), training of staff, and parent education programs.	91	50	53	65
45. (g) Evidence of a formal communication and transportation system to facilitate a child's receiving specialized treatment services for health, education, and emotional disorders.	100	50	66	75
Other:				
46. (h) Evidence of a formalized system by which the multi-professional disciplines can participate with parents in the overall planning and development of the child care setting.	91	83	66	78

APPENDIX VIII

OUTSIDE EVALUATION TEAM OPINIONNAIRE GIVEN TO PARENTS UTILIZING THE IN-CENTER PROGRAM, MAY, 1973

Questions and Possible Responses	Parents' Income		Entrance Date to ICP		Total**
	High (n=17)	Low (n=16)	Early (n=18)	Late (n=15)	(n=33)
*12 Are the hours at the Center convenient for you?					
Yes.	94%	94%	94%	93%	94%
No.	6%	6%	6%	7%	6%
13 Do you feel that the Child Care Center has done all it can to keep you interested and involved in your child's program?					
Has done all it can.	38%	44%	28%	57%	41%
Has done a fair amount.	38%	50%	50%	36%	44%
Could do a little more.	25%	6%	22%	7%	16%
Could do quite a bit more.	0	0	0	0	0
Do you feel your opinion can affect decisions made regarding the program?					
Definitely so.	41%	13%	24%	33%	28%
Probably so.	41%	73%	59%	53%	56%
Probably not.	12%	13%	12%	13%	13%
Not at all.	6%	0	6%	0	3%
1 How many suggestions for improvement have you made to the Staff?					
More than three.	18%	0	17%	0	9%
Two or three.	47%	31%	56%	20%	39%
One.	12%	25%	17%	20%	18%
None.	24%	44%	11%	60%	33%

* The first 11 questions on the questionnaire were on the C^2O and are reported in the previous main section.

** The total percentages are not weighted in any special way; each of the 33 parents responding received equal weight. Thus the "Total" column is not the simple average of either the "Income" or "Entrance Date" columns.

APPENDIX VIII -- CONTINUED

Questions and Possible Responses	Parents' Income		Entrance Date to ICP		Total
	High (n=17)	Low (n=16)	Early (n=18)	Late (n=15)	(n=33)
5. How often have you attended parent discussion groups?					
All of those scheduled.	6%	0	6%	0	3%
Most of those scheduled.	32%	19%	47%	0	26%
Once.	21%	25%	31%	13%	23%
Never.	41%	56%	17%	87%	48%
7. How much has your knowledge about your child increased because of the program?					
Substantially.	13%	6%	12%	7%	9%
A moderate amount.	44%	44%	47%	40%	44%
A little amount.	38%	44%	35%	47%	41%
Not at all.	6%	6%	6%	7%	6%
8. Does your child enjoy being at the Center?					
A great deal.	71%	53%	67%	57%	63%
Most of the time.	29%	40%	33%	36%	34%
Some of the time.	0	7%	0	7%	3%
Not at all.	0	0	0	0	0
19. a) Is the cost of the Center approximate to its value?					
Definitely yes.	63%	50%	44%	71%	56%
Probably yes.	38%	44%	56%	21%	41%
Probably no.	0	0	0	0	0
Definitely no.	0	6%	0	7%	3%
19. b) If the tuition was raised $5 more per week, would you still use the Center?					
Yes.	41%	25%	22%	47%	33%
No.	24%	25%	28%	20%	24%
Uncertain.	35%	50%	50%	33%	42%

APPENDIX VIII — CONTINUED

Questions and Possible Responses	Parents' Income		Entrance Date to ICP		Total
	High (n=17)	Low (n=16)	Early (n=18)	Late (n=15)	(n=33)
3. a) Have you been asked to evaluate your child care worker (that is, the adult who works with your child at the Center)?					
Yes	0	0	0	0	0
No	100%	100%	100%	100%	100%
21. How pleased are you with the abilities of the staff members who work with your child?					
A great deal.	53%	50%	39%	67%	52%
Most of the time.	35%	44%	50%	27%	39%
Some of the time.	12%	6%	11%	7%	9%
Not at all.	0	0	0	0	0
22. a) Have you recommended friends to the Center?					
Yes	88%	87%	94%	79%	88%
No.	12%	13%	6%	21%	13%
22. b) If yes, how many?					
More than three.	33%	17%	25%	27%	26%
Three.	0	25%	13%	9%	11%
Two.	27%	42%	31%	36%	33%
One.	40%	17%	31%	27%	30%
5. Did the staff ever recommend that you take your child to any special medical or health services (e.g., dentist, doctor, physical therapist, eye doctor, or other)?					
Yes	35%	13%	33%	13%	24%
No.	65%	88%	67%	87%	76%

APPENDIX VIII -- CONTINUED

Questions and Possible Responses	Parents' Income		Entrance Date to ICP		Total
	High (n=17)	Low (n=16)	Early (n=18)	Late (n=15)	(n-33)
5. What are your plans for your child for next year?					
Enroll in public school.	22%	17%	21%	19%	20%
Continue in the same Center.	50%	67%	59%	56%	58%
Seek another child care center.	17%	3%	15%	6%	11%
Seek a home day care service.	0	0	0	0	0
Other -- please specify.	11%	13%	6%	19%	12%

APPENDIX IX

CURRICULUM FOR FAMILY HOME CARE TRAINING

WEEK I	Orientation Intellectual and cognitive development in children Activities for cognitive growth
WEEK II	Emotional and social development Communication with children Discipline Activities for emotional and social development
WEEK III	Gross motor and fine motor development Activities to promote motor development
WEEK IV	Developmental assessment Licensure
WEEK V	Safety-first aid
WEEK VI	Nutrition Cooking for children
WEEK VII	Finances of FHC Dealing with parents Policies
WEEK VIII	Review, questions, preparation for business

PROJECTS FOR FHC TRAINING

Case study of child
Order equipment (safety stops of doors, electric outlet covers)
Build a first-aid kit
Make a recipe book and bring several for all to have
Apply for licensure, zoning variance

UNIVERSITY OF COLORADO MEDICAL CENTER
4200 EAST NINTH AVENUE
DENVER, COLORADO 80220

COMPREHENSIVE CHILD CARE PROJECT
COUNSELING-COORDINATION OFFICE
UCMC BOX #2338
TELEPHONE: 394-8988
CHILD CARE CENTER
UCMC BOX #2311
TELEPHONE: 881-2083

JANE E. CHAPMAN PH.D., PROJECT DIRECTOR
PAUL T. BARNES, PH.D., DIRECTOR
COUNSELING-COORDINATION OFFICE
FERN PORTNOY, M.ED., DIRECTOR,
CHILD CARE CENTER

APPENDIX X

SCHOOL-AGE SURVEY

March 26, 1973

Dear Parent:

The University of Colorado Medical Center (UCMC) Child Care Project is interested in sponsoring a pilot project which will provide quality Child Care for school-age children. We expect to base the project at the Palmer School and provide quality services for the children of both Palmer School parents and Medical Center parents. Two programs are planned:

1. A Summer School Program--(1973). This program will be a full-time day camp program offering diverse activities individualized for your child.
2. An After-School Program--(Fall, 1973). This program will be a complementary extension of your child's school day program, with emphasis on recreational activities.

There are numerous reasons why UCMC Child Care staff have a concern about making quality Child Care programs available for school-age children. First and foremost, we are aware of the presence of thousands of "latch-key" children throughout the country, young children who come home from school with the house key around their necks and no supervision until parents arrive home from work. Naturally, both UCMC Child Care personnel and DPS are interested in exploring additional recreational programming for younger children. UCMC Child Care staff are also committed to making available to Medical Center employees and students quality Child Care for all ages of children.

In order to determine in what specific direction to aim our efforts for school-age children, both DPS personnel and UCMC Child Care staff earnestly seek your help. Please respond to the enclosed questionnaire as soon as possible. If you are a Palmer School parent, kindly return it to Mr. Wagner, Principal, Palmer School; if a Medical Center parent, please return it to the UCMC Child Care Office, Box 2338. Medical Center people can return the questionnaire via campus mail.

Many thanks for your cooperation.

George Wagner, Jr., Principal
Palmer School

Fern Portnoy, M.Ed., Director
UCMC Child Care Programs

Norma Edelman, President
Palmer School P.T.A.

Paul Barnes, Ph.D., Director
UCMC Child Care Office

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APPENDIX X -- CONTINUED

Return to: Principal's Office, Palmer School (if a Palmer School parent), or UCMC Box 2338 (if a UCMC parent)

Name_____

Home Address_____ Zip Code_____

Home Tel. No._____ Work Tel. No._____

GENERAL INFORMATION

1. Do you currently use Child Care on a regular basis for any of your children, independent of age? Yes_____ No_____

   If yes, is the child(ren) cared for by (1) a licensed day care mother_____, (2) a regular babysitter_____, (3) a child care center, pre-school, nursery school, etc._____, (4) only during his/her after-school hours_____, or (5) some other arrangement (please specify)_____.

2. Is your child(ren) bussed to and/or from school? Yes_____ No_____

SURVEY OF CHILD CARE NEEDS FOR SCHOOL-AGE CHILDREN

I. How many children do you have between ages 5 and 12?_____

	Name	School	School Location	Present Grade	Hrs. in School
1.					
2.					
3.					
4.					

Please circle your child(ren)'s name above, if you expect that he/she may attend a different school during the 1973-1974 school year.

Do you consider quality Child Care as a necessary and/or valuable addition to the experiences your child(ren) is already receiving from his current school?

Yes_____ No_____

If no, could you please help us by briefly stating why you do not currently regard Child Care for your school-age child(ren) as necessary and/or valuable:

_____

_____

_____

If yes, we particularly ask that you finish Sections II and III of this questionnaire.

APPENDIX X -- CONTINUED

II. A.

	Name of Child	Summer Day Camp--Summer, 1973 (Yes or No)	Exact Dates Desired for Summer Day Camp	After-School Care--Fall, 1973 (Yes or No)
1.				
2.				
3.				
4.				

B. DPS and the Child Care Project at UCMC are very much interested in parents' wants and feelings around all aspects of Child Care programming. Therefore, if you do perceive a need for Child Care for your school-age child(ren), could you write a short paragraph indicating the kinds of experiences that you desire for your child.

Please list below which experiences you want your child(ren) to have in a summer day camp program and which in an after-school program:

	Summer Day Camp		After-School Program
1.		1.	
2.		2.	
3.		3.	
4.		4.	
5.		5.	
6.		6.	

What does your child(ren) like to do right now in school?

What does your child(ren) like to do right now after school?

What does your child(ren) like to do during the summertime?

APPENDIX X -- CONTINUED

III. Additional Information Needed:

The availability of Child Care programming for your school-age child(ren) is very much dependent upon parent support. Therefore, we need to know:

1. If you currently have Child Care for your school-age child, what are you paying?

   $_____ per hour

   $_____ per day

   $_____ per week

2. What are you realistically able to pay for a good quality Child Care program for your school-age child(ren)?

Summer Day Camp	After-School Care
$_____ per hour	$_____ per hour
$_____ per day	$_____ per day
$_____ per week	$_____ per week

3. On a scale of 1 (low) to 5 (high), would you please rate how valuable and/or necessary you perceive quality Child Care for your school-age child(ren) to be. If you do not have a school-age child, please omit this item.

1 2 3 4 5
(Low) (High)

Please return as soon as possible to:

Principal's Office, Palmer School
(if you are a Palmer School parent)

Child Care Office, UCMC Box 2338
(if you are a UCMC parent)

Thank you.

APPENDIX XI

Action and Interaction Data of Advisory Board Meetings #1--#18, 7/72--4/73.

Content Areas	FI Given to B by S*	FB Asked of B by S	FB Given to S by B	FB Given to B by B**	FI Asked of S by B	Decisions	Totals of Focus
Board Function	4	4	6	19	4	12	49
Board Membership	2	0	4	4	0	8	18
Board Structure	1	0	0	0	0	7	8
SUB-TOTAL:	7	4	10	23	4	27	75
Project Goals and Progress	18	1	0	5	1	0	25
Personnel Issues	8	1	0	0	1	0	10
Facilities and Equipment	7	1	1	0	0	1	10
Consumer Utilization of Model	13	4	13	7	4	18	59
Budget and Consumer Fees	15	2	8	1	4	11	41
Service Program Quality Issues	28	4	6	0	7	30	75
Dissemination	2	0	0	0	0	4	6
SUB-TOTAL:	91	13	28	13	17	64	226
TOTAL:	98	17	38	36	21	91	301

*FI = Feed-in
FB = Feedback
B = Board
S = Project Staff

**Issues that were sent to Board sub-committee and returned to full Board.

APPENDIX XII

UNITED BANK OF DENVER SURVEY

1. Name_____

2. Position_____

3. Department_____

4. Telephone or extension_____

5. Home address_____ 6. Zip_____

7. Home phone_____

8. Full Time ☐ Part Time ☐

9. How long have you worked for the United Bank of Denver?

☐ 0-1 year ☐ 1-2 years ☐ 2-4 years ☐ 4-6 years

☐ 6 years +

10. Marital Status: ☐ S ☐ M ☐ Sep. ☐ Div. ☐ W

11. Sex: ☐ Male ☐ Female

12. It would be helpful to us in analyzing the results of this questionnaire if you would indicate the racial or ethnic background of your children. This is not a requirement.

☐ Anglo ☐ Black ☐ Chicano ☐ Oriental

☐ American Indian ☐ Other_____

13. Working Status

☐ One parent working

☐ Both parents working

☐ One parent working, one parent attending school full time

☐ Other_____

14. Are you the sole support of your children? ☐ Yes ☐ No

15. Total Family Income

- ☐ $ 0 - 3,999
- ☐ 4,000 - 4,999
- ☐ 5,000 - 5,999
- ☐ 6,000 - 7,999
- ☐ 8,000 - 9,999
- ☐ $10,000 - 11,999
- ☐ 12,000 - 14,999
- ☐ 15,000 - 19,999
- ☐ 20,000 or above

16. Have you ever in your work history had to leave your place of employment due to child care problems?

☐ Yes ☐ No

17. To what extent do you feel your comfort with your child care arrangement influences your performance on your job?

☐ Not at all ☐ Somewhat ☐ Very much

18. To what extent would the existence of child care facilities at the United Bank of Denver influence your decision to continue working at your present job?

☐ Not at all ☐ Somewhat ☐ Very much

19. Hypothetically - If you were out looking for a job right now, would the availability of quality child care services influence your accepting a job?

☐ Not at all ☐ Somewhat ☐ Very much

20. If when you had your children, if you are pregnant right now, or if you were to become pregnant very soon, would the existence of high quality child care influence the length of the maternity leave you might take (have taken)?

☐ Not at all ☐ Somewhat ☐ Very much

21. In the past six months, how many days would you estimate you lost time from work due to:

a. child care problems (child is ill, regular sitter unavailable, etc.) _____

b. child related problems (visiting child's school for parent-teacher conferences, taking child to Dr.) _____

22. In the past six months, how many times would you estimate you have been late or have had to leave early due to child care concerns or problems?

_____

23. Please list all your children:

	Name	Age	Birthdate	(Place check mark by children for whom you would like child care services to be available)
1.				
2.				
3.				
4.				
5.				
6.				

24. How are your children being cared for now? (Check as appropriate)

a ☐ Relatives
b ☐ Neighbors
c ☐ Older children in family
d ☐ Babysitter in my home
e ☐ Other (explain) _____
f ☐ Babysitter out of home
g ☐ Mother/father cares for child in home
h ☐ Head Start - Preschool
i ☐ Professional Day Care Center

25. How much are you currently paying for child care?

(per child per day, _____) or (per child per week, _____)

26. Would you be interested in having your child (children) utilize United Bank of Denver child care services?

☐ Yes ☐ No

If no, please explain _____

_____

27. We would like your help in determining which of the following to incorporate into a quality child care service or program. (please check as many as you would like to see included)

a. _____ Pre-school education

b. _____ Nutrition counseling

c. _____ Health counseling

d. _____ Bilingual program

e. _____ Multi-cultural program.

f. _____ Physical activity program

g. _____ Art and music

h. _____ Parent counseling about behavior

i. _____ Field trips

j. _____ Before or after school program for school age children

k. _____ Evening or weekend child care

l. _____ Facilities for your sick child

m. _____ Summer or school holiday program for school age children

n. _____ Child Care Center

o. _____ Family Home Care

p. _____ Infant Center

q. _____ Toddler Center

r. Other (please specify _____

_____

28. Which days of the week would you use child care facilities?

_____

29. Which hours of the day would you use child care facilities?

_____

30. Where do you prefer child care services to be located?

☐ Near where you work

☐ In your own neighborhood

31. Would you be more likely to use child care services if transportation were provided for your child?

☐ Yes ☐ No

32. What is the maximum you would pay for high quality child care?

_____ per day per child _____ per week per child

33. Would you be interested in participating in:

a. Planning stages of a child care program? Yes_____ No_____

b. The on-going program planning? Yes_____ No_____

34. If you were to choose not to use United Bank of Denver related child care services, would you be interested in a referral-counseling service to assist you in finding appropriate child care services for your child in the metro community?

Yes_____ No_____

DATA TABULATION

Question #	Measure	Rationale
2	Frequency and percentage	This will be helpful in determining if all position levels would be interested in child care programs. We imagine your personnel department has a standard position classification breakdown.
6	Frequency count within Zip Code	Helpful in correlating with question #30 and in determining if employees wish central or satellite child care facilities.
8	Percentage	Relates to hours and days for child care utilization. We have assumed you have part time employees. Keep in mind on this question and questions #21 and 22 that many cost analyses are based on full time equivalent children.
9-14	Frequency and percentage	To better understand nature of population you might be serving.
15	Frequency and percentage	Relates to amount willing to pay for quality child care, question #32, and may help in determining a sliding scale.
5, 18	Frequency and percentage	Relates to issue of employee turnover in the abstract (we recognize this) but nonetheless perhaps crucial.
17	Frequency and percentage	Comfort relates to questions 21 and 22, as well as speaking to employee productivity.
19	Frequency and percentage	While hypothetical - perhaps will assist in answering if availability of child care might draw high quality employees.
20	Breakdown by female respondents for frequency and percentage	Assuming you replace and retrain employees to cover for women on maternity leave, this might be a crucial question.
21, 22	Mean and range	Relates to productivity - time lost from job, etc.

Question #	Measure	Rationale
23	Frequency by age category of the children for whom child care is desired	Necessary for determining program design - figuring staff ratios, etc. (different age groups require different staffing patterns and different equipment). In doing age breakdown, we suggest you follow state regulation guidelines as needed for different types of facilities, i.e., Infants, 0-10 months; Toddler Center, 10 months to 2-1/2 years; Pre-school, 2-1/2 to 6 years; School age, 6 to 12 years.
24	Frequency and percentage for each category	Relates to respondents' preferred level of comfort, question #17, and questions 21 and 22. Also relates to over-all program design.
25	Mean and range	Necessary data for determination of fees.
26	Frequency and percentage We suggest you code no responses based on content.	Basic data for need determination along with question #23. Cutoff - discrimination item for questions 27 through 34.
	[If yes on #26, tabulate responses on questions 27 - 34.]	
27	Frequency and percentage breakdown; breakdown further a-i, j-r	Basic data for preferred program content and program offering determination and appeal according to ethnic characteristics, etc.
28, 29	Frequency, percentage breakdown on full time, particular days and hours.	Necessary data for program determination and basic need, e.g., how many full time equivalent children would United Bank of Denver need to provide services for.
30	Frequency, percentage.	See #6 above.
31	Frequency, percentage	Helpful to program determination and related to cost factors and responses to question #30.
32	Mean and range	Needed for cost analysis and potential financial role of United Bank of Denver.

Question #	Measure	Rationale
33	Breakdown names on both a and b	Gives you contact people if you decide to go ahead and desire parent consumer input initially or in the future (e.g., Employee Advisory Board).
34	Frequency and percentage	If you decide against a full scale child care program, availability of a counseling referral service might be an alternative for you as a personnel service.

SUGGESTED CORRELATIONAL STUDIES

Questions		Rationale
#6 Zip Code (grouped according to sector, e.g., S.E., N.E., S.W., N.W.)	with #30 (location) and #34 (referral service)	May prove helpful in determining central vs. satellite child care programs. May help in determining if those living farthest from downtown would rather have a referral service.
#2 Position Classification #13 Working Status #14 Sole Support	with questions 16, 17, 21, 22, 29, 30	Will help in answering which employee level has the most difficulty with child care. Also, look at this in relation to age of children. You may wish to provide service most appealing to the employees experiencing greatest child care related work performance problems. By further breaking down data on working status and sole support, additional data may help you in understanding which subgroup of your employees is experiencing greatest difficulties.
#16 How presently cared for	with #17, #21, and #22	Which setting presently utilized by your employees is most unstable.
#9 Length of time with United Bank of Denver #10 Marital Status #1 Sex #12 Ethnic and racial #3 Working Status #4 Sole support	with #24, present care situation	Data on your employees as it relates to child care.
#'s 9, 10, 11, 12, 13, 14	with #27, program components, and #34, referral service	Type of program desired according to employee profile.

Questions		Rationale
#15 Total Family Income	with #32, Maximum willing to pay for child care	Crucial for determination of fee you might be setting and potential financial role of United Bank of Denver
#23 Age breakdown on children for whom care is requested	with #21, #22	May be helpful in determining which age groups your program might serve.
#15 Total Family Income	with #23, by age category	Useful in determining generative fee potential.

APPENDIX XIII

A BILL FOR AN ACT

CONCERNING A STATE-INCENTIVE GRANT PROGRAM OF CHILD CARE PROGRAMS, AND MAKING AN APPROPRIATION THEREFOR.

"SECTION 1. Chapter 119, Colorado Revised Statutes 1963, as amended, is amended BY THE ADDITION OF A NEW ARTICLE to read:

ARTICLE 15

Early Childhood Development

119-15-1. Definitions. (1) As used in this article, unless the context otherwise requires:

(2) "Department" means the department of social services.

(3) "Incentive grant" includes both cash and in-kind contributions.

(4) "Executive director" means the executive director of the department of social services.

(5) "Model program" or "model project" means any program established and funded pursuant to this article.

(6) "Statewide referral service" means a centralized service which dispenses information concerning child care resources in the various communities of this state.

119-15-2. Office created and purpose. (1) (a) There is hereby created an office of early childhood development in the department of social services, which office shall be responsible to the executive director of the department. Within the limits of available appropriations, the department shall institute a program to:

(b) Develop models for employers and grantees to creatively explore, demonstrate, and study the establishment of high quality child care programs;

(c) Give initial impetus and assistance in the creation of programs which may, at the end of the funding period, become self-supporting;

(d) Explore the role of this state in stimulating the growth of new child care resources in the form of grants for projects which shall serve as demonstration models;

(e) Conduct a complete survey of existing early childhood development programs throughout this state and utilize this information for a statewide referral service;

(f) Determine what additional types of programs or services are needed, for which children, and where such programs or services should be located;

(g) Assist the public and the general assembly to become knowledgeable of existing and needed early childhood programs in this state;

(h) Assist public agencies and private organizations toward the orderly development and expansion of child care facilities and programs.

119-15-3. Duties of office. (1)(a) The office of early childhood development is charged with the responsibilities of:

(b) Establishing written guidelines for project funding;

(c) Publicizing by appropriate means the funds available under this article and requesting project proposals;

(d) Reviewing and summarizing project proposals and making grants;

(e) Reviewing funded projects to insure that guidelines are met;

(f) Evaluating overall program effectiveness and reporting same to the governor and the general assembly on or before February 1 of each year;

(g) Collating and summarizing information gathered from all projects funded under this article and submitting to the governor and the general assembly on or before July 1, 1977, a comprehensive summation of overall program findings with recommendations for the future role of this state;

(h) Promulgating rules and regulations pursuant to article 16 of chapter 3 C.R.S. 1963, for the effective administration of this article.

119-15-4. Advisory board. The state board of social services shall appoint an advisory board to advise the office of early childhood development programs in the discharge of its functions.

119-15-5. Eligibility for incentive grant. (1) (a) In order to be eligible for matching under this article, each applicant shall:

(b) Provide, or plan to provide direct child care services in facilities licensed by the department;

(c) Provide child care for a specific, defined population or assist a specific, defined population to locate and utilize child care facilities in their community more effectively;

(d) Base any fee charged for child care services on a sliding scale according to total family income subject to the requirement that full-cost fees shall be charged to consumers who have total family income of more than ten thousand dollars per annum;

(e) Be a nonprofit corporation, association or governmental entity;

(f) Demonstrate a significant degree of parental involvement in initial project planning and in on-going project operation;

(g) Maintain a complete financial record as prescribed by the department so as to permit an audit of records by the state auditor.

(2) (a) The office of early childhood development shall seek to fund projects which:

(b) Develop a wide variety of child care programs throughout this state, which may include, but are not limited to, infant nurseries, toddler nurseries, children's centers, family home care programs, school-age children's

programs, referral services and counseling, or alternative child care for ill children;

(c) Develop programs for expansion of child care resources for selected populations;

(d) Serve groups of a wide variety of ethnic, cultural, and socio-economic populations;

(e) Demonstrate the most economical use of funds by providing the greatest amount of high quality child care for the least expense;

(f) Limit the amount of the incentive grant to one dollar by the state of Colorado for every two dollars contributed by the grantee, either in the form of direct subsidy or from fees charged to consumers, or both. No grant shall continue for a period longer than two years from date of funding.

SECTION 2. Appropriation. (1) (a) There is hereby appropriated, out of any moneys in the state treasury not otherwise appropriated, to the department of social services for allocation to the office of early childhood development, for the fiscal year commencing July 1, 1974, the sum of

or so much thereof as may be necessary, which shall be available to fund:

(b) A comprehensive survey of existing research done in the area of child care and existing child care resources and needs in this state to be completed by July 1, 1976;

(c) The establishment of a statewide referral service;

(d) Incentive grants on a matching fund basis, as described in SECTION 1 (2) (f).

SECTION 3. Effective date. This act shall take effect July 1, 1974.

SECTION 4. Safety clause. The general assembly hereby finds, determines, and declares that this act is necessary for the immediate preservation of the public peace, health and safety.

HOUSE BILL 1258

FISCAL NOTE Total Appropriation: $800,000

Projected Administrative Costs:

Director - SSSS IV at step 3 $1,341 + Ret + HI x 12 months	$ 17,588
Program Assistant - SSSS III at step 3 $1,244 + Ret + HI x 12 months	16,317
Fiscal Assistant - SSSS III at step 3 $1,244 + Ret + HI x 12 months	16,317
Clerical - Senior Clerk-Steno at step 1 $505 + Ret + HI x 12 months	6,695
Total Salaries	56,971
Capitol Outlay 1 @ $880 3 @ $505	2,380
Travel 3 @ $1,500	4,500
Operating 8% of salaries	4,553
Total Projected Administrative Costs	$ 68,350

Estimated cost of Referral Service and Survey $ 65,000

Pilot Programs:

7-10 @ $50,000 - $75,000 $666,650

If used totally at .333 expenditure for six months, total amount available for child care + 1,999,950

21 days/month x 6 months at $7.50 maximum per day = 2,116 children/day

HOUSE BILL 1258

PROGRAM NOTE

1. Funding may be granted to non-profit subordinate corporations of industries, institutions of higher learning, or any other non-profit group in the community. The purpose of the bill is to make assistance funding available to groups which are generally ineligible for Federal funding under Title IV -A or -B.

2. Applicants have the option of providing their own services, of sub-contracting with existing community resources, or forming cooperative agreements with other community resources or agencies, but are not limited to this. Sub-contracts may be with profit making enterprises.

3. High quality child care programs should have formal systems for delivery of supportive services such as psychological screenings, speech, hearing, vision, etc. This may occur in any number of ways, for instance,

   a) in those industries or organizations with facilities of this type, they may be made available to the consumers of child care services.

   b) those industries or organizations which elect to join in a cooperative arrangement for child care facilities may also elect to pool services of this nature

   c) an industry or organization may elect to utilize an existing community resource in any number of ways, i.e., subcontracting, utilization of its premises for training purposes, etc.

4. Programs should demonstrate a commitment by the industries involved to assume costs or in some way continue operation of the program following the funding period, provided the program is successful. In addition, the Office of Early Childhood Development may elect to require an increased proportion of funding during the three year period governed by this act as sufficient proof that the industry involved will continue to support the program after the end of pilot project funding.

5. All child care programs which are funded under this act are to be reviewed periodically by the Office of Early Childhood Development. They shall be required to submit written reports of sufficient frequency to allow the Office of Early Childhood Development to adequately evaluate their progress. In addition, the Office of Early Childhood Development shall be expected to make on-site visits.

SYMPOSIUM PARTICIPANTS

Aragon, Corina E.	Legal Research Assistant Equal Employment Opportunity Commission
Barcus, Louise	Company Nurse Honeywell, Inc.
Barnewall, Marilyn	New Products and Communication Manager United Bank of Denver
Bromley, Kathleen C.	Secretary/Treasurer Midcontinent Consultants Inc.
Darrow, Susan L.	Legal Research Assistant Equal Employment Opportunity Commission
Engen, Phyllis J.	Personnel Manager National Farmers Union Service Corporation
Ihrig, Fritz G.	Corporate Director Industrial Relations Samsonite
Knight, Rick	JFK Child Development Center
James, Judy	Appraisal Services Supervisor First National Bank
Lehman, Velma F.	Lead Instructor Early Childhood Education Community College of Denver - North
Miller, Dorothie	Senior Employment Specialist Dow Chemical, U.S.A. Rocky Flats Division
Milway, Phyllis L.	Educational Coordinator Gates Rubber Company
Nickerson, Ann	Day Care Supervisor Denver Department of Welfare
Quinn, Don	Public Affairs Administrator United Bank of Denver
Scarborough, Dr.	
Stuska, Sue	Comm. and Pers. Service Community College of Denver - North

Barbeito, Carol L.	Executive Director Mile High Child Care Association
Bowles, William D.	President Midcontinent Consultants Inc.
Cohen, Cathy W.	Director, EPDA Training Program Community College of Denver
Fischer, Dr. Henry L.	JFK Child Development Center
Haynes, Anna Jo	Field Supervisor EPDA Training Program
Mizner, Joanne	JFK Child Development Center Director of Preschool
Read, Sonya	JFK Child Development Center Coordinator, Educational Programs
White, Roger	Public Relations Officer Colorado National Bank

XO-06 I.D. # / / / / / / / /

APPENDIX XV

FINAL FOLLOW-UP

Family Name _____ Child's Name _____ Date _____

1. Is placement terminated? Yes _____ No _____

   If yes, when? _____

   Why?

   _____ a. Caregiver moved or went out of business.

   _____ b. Need no longer exists.

   _____ c. Family moved.

   _____ d. Setting unsatisfactory for parent (explain) _____

   _____

   _____ e. Setting inappropriate for child's needs (explain) _____

   _____

   _____ f. Arrangement unsatisfactory for caregiver.(explain) _____

   _____

   _____ g. Other (explain) _____

   _____

2. If your arrangements were terminated, did you arrange for alternate care?

   Yes _____ No _____

   What kind? _____

   How did you make arrangements?

   _____ a. through a friend.

   _____ b. other referral service.

   _____ c. through CCO.

   _____ d. "yellow pages."

3. If any answer besides 2c, why did you choose not to use the CCO?

   _____

   _____

4. Does (did) your child enjoy being in the setting?

   _____ always

   _____ most of the time

   _____ some of the time

   _____ not at all

5. Would you or have you recommended the setting to a friend? Yes _____ No _____

CCO-06

6. How well did the placement meet your desires in regard to:

Time Avail.	Cost	Location	
_____	_____	_____	extremely well
_____	_____	_____	quite well
_____	_____	_____	slightly well
_____	_____	_____	not well at all

7. How satisfied were you with the amount of time required to find child care through the CCO?

_____ extremely satisfied
_____ satisfied
_____ unsatisfied
_____ extremely unsatisfied

8. Would you use the CCO in the future when and if new child care needs arise or were to arise?

_____ exclusively
_____ in conjunction with other efforts (specify: _____ _____)
_____ not at all (why? _____)

9. Would you or have you recommended the CCO to a friend? Yes _____ No _____

10. Did the availability of help through the CCO enable you to maintain employment with the UCMC? Yes _____ No _____ Other? Yes _____ No _____

11. The Child Care Project would like your opinion about what you think are important aspects of a child care arrangement. Please rate from 1 (most important) to 8 (least important) the following:

_____ a. The hours during the day when the child care is available.
_____ b. The costs (charges) to the child's parents.
_____ c. Age appropriate activities in the setting.
_____ d. The days of the week the setting offers care.
_____ e. The nutrition regularly offered to the children.
_____ f. The children being able to "get outside" when the weather is o.k.
_____ g. Location of the child care setting.
_____ h. The way the staff gets along with the children.

12. Did you or your child experience any problems with the setting, caregiver, child care arrangements, etc. (other than those leading to termination)? Describe

Time recorded ___

CCO-11 I.D. # / / / / / / / /

APPENDIX XVI

FINAL FOLLOW-UP

WITH SETTING

Family Name _____ Child's Name _____ Date _____

1. Is placement terminated? Yes _____ No _____

If yes, when? _____

Why?

_____ a. Caregiver moved or went out of business.

_____ b. Need no longer exists.

_____ c. Family moved.

_____ d. Setting unsatisfactory for parent (explain) _____

_____

_____ e. Setting inappropriate for child's needs (explain) _____

_____

_____ f. Arrangement unsatisfactory for caregiver (explain) _____

_____

_____ g. Other (explain) _____

_____

2. Does the child enjoy being in the setting?

_____ always

_____ most of the time

_____ some of the time

_____ not at all

3. Would you refer this family to other caregivers whom you know?

Yes _____ No _____ Reservations _____

_____

4. Did you or the child experience any problems? _____

_____

_____

CCO-10

I.D. # / / / / /

APPENDIX XVII

CHILD CARE QUESTIONNAIRE

For Families Not Using the

Counseling-Coordination Office

1. Family Name _____ Date _____
2. Marital Status (please circle): Single Married Divorced Widowed Separated
3. Name and birthdates of children (check name of child for whom this questionnaire is relevant):

Name	Birthdate
_____	___/___/___
_____	___/___/___
_____	___/___/___
_____	___/___/___

4. Is child care critical in obtaining or maintaining employment or student status?
   Yes _____ No _____
5. What kind of child care setting is your child in at the present time?
   - Child Care Center _____
   - Preschool _____
   - Family Day Care _____
   - Babysitter in my home _____
6. Is this: full-time care? _____ part-time care? _____
7. How many months has your child been in this setting? _____ months
8. Does your child enjoy being in the setting?
   - _____ always
   - _____ most of the time
   - _____ some of the time
   - _____ not at all
9. Would you or have you recommended this setting to a friend? Yes _____ No _____
10. How well does this setting meet your desires in regard to:

Time Avail.	Cost	Location	
_____	_____	_____	extremely well
_____	_____	_____	quite well
_____	_____	_____	not so well
_____	_____	_____	not at all

11. How did you locate this setting?

_____ yellow pages
_____ Maternal and Child Health list
_____ Mile High Child Care Association/United Fund referral
_____ bulletin board notice
_____ recommended by a friend or relative
_____ referred by another child care facility
_____ other (specify) _____

12. The Child Care Project would like your opinion about what you think are important aspects of child care arrangements. Please rate from 1 (most important) to 8 (least important) the following:

_____ a. The hours during the day when the child care is available.
_____ b. The costs (charges) to the child's parents.
_____ c. Age appropriate activities in the setting.
_____ d. The days of the week the setting offers care.
_____ e. The nutrition regularly offered to the children.
_____ f. The children being able to "get outside" when the weather is o.k.
_____ g. Location of the child care setting.
_____ h. The way the staff gets along with the children.

13. Prior to our contacting you, did you know about the Child Care Project's Counseling-Coordination Office which provided child care referral services? Yes _____ No _____

14. If yes, could you check your reason for not seeking our assistance in finding child care.

_____ I did not think the Counseling Office would be very helpful.
_____ I found child care on my own.
_____ Other (specify) _____
_____

15. How satisfied were you with the amount of time required to find child care?

_____ extremely satisfied
_____ satisfied
_____ unsatisfied
_____ extremely unsatisfied

.CO-02
Request # ____

I.D. # /_/_/_/_/_/_/

APPENDIX XVIII

REQUEST FOR CHILD CARE

1. Name of person(s) making contact _____ Date _____

. Address _____ City _____ Zip _____

Home phone _____ Eligibility: No info ____ UCMC ____ Other ____

UCMC ext. _____ UCMC container # _____ Other work phone _____

UCMC department _____

. Child's name _____ Relationship of contact person to child _____

4. Child's sex: M F Birthdate __/__/__ Age _____

5. Care Requested:

CCC FHC SAP/UCMC CR UNSPEC _____

Other _____ _____

Days _____ Hours _____ _____

Comments: _____ _____

_____ _____

Need date _____ Cost range _____

Desired location _____

Two children in same setting _____

6. Is child care critical in maintaining ____ or obtaining ____ employment/student status? Yes ____ No ____

7. Phone referral ____ matched placement ____

Recorded time spent /7

CODED —

CCO-04 I.D. # / / / / / / / /

APPENDIX XIX

CHILD CARE AND FAMILY QUESTIONNAIRE

Family Information

Last Name _____ Today's Date _____

Mother's Name _____ Birthdate: / /

Father's Name _____ Birthdate: / /

Martial Status (please circle): Single Married Divorced Widowed Separat

Date of Marriage: _____ Date of Divorce, Separation or Death of Spouse _____

Names and birthdates of children (check name of child for whom care is being sought:

Name	Birthdate
_____	/ /
_____	/ /
_____	/ /
_____	/ /

1. Mother is (check one):

_____ a. Presently working.

_____ b. Recently employed and will begin work on (date) _____

_____ c. Job hunting.

_____ d. Student.

_____ e. Has chosen not to work.

_____ f. Other (please specify) _____

2. If you checked a, b, or c above, please give job title and brief description of present job or type of future employment _____

_____

_____

If you checked d above, what are you studying and what degree will you earn?

_____ Date degree expected _____

3. Father is (check one):

_____ a. Presently working.

_____ b. Recently employed and will begin work on (date) _____

_____ c. Job hunting.

_____ d. Student.

_____ e. Has chosen not to work.

_____ f. Other (please specify) _____

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APPENDIX XIX - CONTINUED

4. If you checked a, b, or c above, please give job title and brief description of present job or type of future employment. _____

_____

_____

If you checked d above, what are you studying and what degree will you earn?

_____ Date degree expected _____

5. Where do you prefer child care (put number "1" next to first choice, "2" next to second choice, and so on)?

_____ Near home.
_____ Near place of mother's employment.
_____ Near place of father's employment.
_____ Midway between home and work for mother.
_____ Midway between home and work for father.
_____ Convenient to both mother's and father's places of employment.
_____ Near child's school.
_____ Other (specify) _____

If you checked other than "near home," near what address do you want care?

_____ Zip _____

6. Total family income from all sources including child support (if applicable) falls in which range?

_____ a. 0-4,999
_____ b. 5,000-9,999
_____ c. 10,000-14,999
_____ d. 15,000 and up

7. Please check your single most important reason for seeking child care at this time (check only one):

_____ Work or school is personally important for my growth and development.
_____ I must work or attend school to totally support or lend financial support to my family.
_____ I feel a group experience for my child is important for his/her growth and development.

8. If your child were to become ill and unable to attend regular child care arrangements, which of the following would apply (check all that apply):

_____ Mother does not work and thus is available.
_____ Father does not work and thus is available.

8. _____ Mother would stay home from work or school.
_____ Father would stay home from work or school.
_____ Parents would alternate taking care of child.
_____ Relative would be available to care for child.
_____ Friend would be available to care for child.
_____ Mother would lose wages, sick or vacation days if she stayed home.
_____ Father would lose wages, sick or vacation days if he stayed home.
_____ Hire an unrelated babysitter to care for the child.

9. Has mother ever terminated her employment or student status due to problems related to child(ren) or child care arrangements?
Yes _____ No _____ Please explain _____

10. Has father ever terminated his employment or student status due to problems related to child(ren) or child care arrangements?
Yes _____ No _____ Please explain _____

11. Please complete the following chart of mother's work experience for the previous twenty-four months. If employed full time, enter F above appropriate months; if part-time, enter P.

1971	/	/	/	/	/	/	/	/	/	/	/	/
	J	F	M	A	M	J	J	A	S	O	N	D
1972	/	/	/	/	/	/	/	/	/	/	/	/
	J	F	M	A	M	J	J	A	S	O	N	D
1973	/	/	/	/	/	/	/	/	/	/	/	/
	J	F	M	A	M	J	J	A	S	O	N	D
1974	/	/	/	/	/	/	/	/	/	/	/	/
	J	F	M	A	M	J	J	A	S	O	N	D

APPENDIX XIX - CONTINUED

12. The Child Care Project would like your opinion about what you think are important aspects of a child care arrangement. Please rate from 1 (most important) to 8 (least important) the following.

_____ a. The hours during the day when the child care is available.
_____ b. The costs (charges) to the child's parents.
_____ c. Age appropriate activities in the setting.
_____ d. The days of the week the setting offers care.
_____ e. The nutrition regularly offered to the children.
_____ f. The children being able to "get outside" when the weather is o.k.
_____ g. Location of the child care setting.
_____ h. The way the staff gets along with the children.

C'D-04 I.D. # / / / / / / / /

Family Name _____ Child's Name _____

13. How many different child care arrangements has this child had since birth: _____
From your point of view, how would you rate your child's present or most recent experience (circle a number)?

1 2 3 4 5

(unsatisfying) (satisfying)

14. Please check and briefly describe the following events if they have occurred in the family during the child's life time. Record the child's age at the time the event occurred.

a. Death in the immediate family or among close friends _____ Child's age _____
Who _____

b. Divorce or separation of parents. _____ Child's age _____

c. Job or school related difficulties. _____ Child's age _____
Describe _____

d. Severe physical or mental illness. _____ Child's age _____
Who was ill, what was the nature of illness _____
_____

e. Separation of child from family. _____ Child's age _____
Describe _____

f. Financial difficulties. _____ Child's age _____
Describe _____

g. How many changes in residence have you made in this child's lifetime? _____
What was the age of the child at each move? _____

h. Arrival of new family member to live in household (siblings, grandparents, etc)
Who _____ Child's age _____
Who _____ Child's age _____

i. Alcoholism, drug use or abuse. _____ Child's age _____
Explain _____

j. Any special difficulties presently occurring in your family which may be affecting your child? _____
_____
_____
_____

CCO-04

APPENDIX XIX - CONTINUED

15. Please rank order the following as they relate to what you want for your child in a child care setting. (Write "1" next to most important, "2" next to second most important, and so on).

_____ Learning to get along with others.
_____ Learning (pre-academic) kinds of experiences.
_____ Special services, e.g., psychological, health, etc.: direct services or consultation.
_____ Physical development.
_____ Art.
_____ Music.
_____ Field trips.
_____ Physical health and safety.
_____ Other _____
_____

Health and Developmental History

Pregnancy and Birth:

16. Health of mother during pregnancy: Excellent _____ Fair _____ Poor _____
17. Was the child premature? Yes _____ No _____
If yes, how early was the delivery? _____ weeks
18. Birth weight: _____lbs. _____ oz.
19. Describe any problems during pregnancy (e.g., bleeding, fainting, illness, medications). _____
_____
_____
20. Was the birth process unusual (e.g., prolonged labor, Cesearian, breech, delay in breathing, forcep delivery, etc.)? Yes _____ No _____
If yes, describe _____
_____
_____
21. Any difficulties during the first weeks for infant or parents? Yes _____ No ___
If yes, describe _____
_____
_____

CCO-04 APPENDIX XIX - CONTINUED

12. Please indicate and describe if your child has had any of the following:
    a. convulsions _____
    b. hospitalization _____
    c. unconsciousness _____
    d. fall from height _____
    e. accidental poisoning _____
    f. non-routine illness (e.g., kidney infection, pneumonia) _____
    _____
    g. accident _____
    h. serious chronic illness _____
    i. allergies _____

13. Does your child presently have any eating, sleeping problems? Yes ____ No ____
    If yes, describe _____
    _____
    _____

14. Does your child have any food allergies or medication needs which would affect child care placement? Yes _____ No _____
    If yes, describe _____
    _____
    _____

15. Is your child toilet trained? Yes _____ No _____
    Accidents? Yes _____ No _____ Times per week _____

16. How many languages are spoken in your home: _____ Which ones _____
    _____

17. Would you prefer a child care placement where a language in addition to English is spoken? Yes _____ No _____
    What language? _____

18. Is there anything unique or special about your child that would be important in making child care arrangements? _____
    _____
    _____

CODED / /

APPENDIX XIX - CONTINUED

RESEARCH PARTICIPATION

I understand that by utilizing the child care counseling and referral services of the University of Colorado Medical Center's Office of Child Development Counseling-Coordination Office I am participating in a research and demonstration project. I give my consent for the Project to use information gained through questionnaires, interviews and evaluation for publication in scholarly journals and dissemination to other professionals in the field. This information will maintain the anonymity of my family.

I give my consent for the University of Colorado Medical Center Comprehensive Child Care Program to release such information concerning my family to any agency (which might provide service to my family), provided that this information will be kept confidential by that agency. I release the University of Colorado Medical Center Child Care Program from all legal responsibility or liability from such action.

_____

(Signature)

_____

(Date)

_____

(Witness)

I.D. # / / / / / / / / /

APPENDIX XX

ON-GOING FOLLOW-UP

FAMILY _____ Setting _____

Family Name _____ Child's Name _____ Date _____

1. Is placement terminated? Yes _____ No _____
   If "yes," go to final follow-up form.
2. How do you like the arrangements?

3. Have there been any problems with the {family / setting} ?

   } Initiate Problem Paper

4. Have there been any concerns about the child?
   Does the child cry a lot?
   Is he withdrawn?
   Has his toilet training lapsed?
   Has he gone back to baby talk?
   Is he unusually aggressive?

5. Have child care arrangements resulted in any especially good things for your child?

6. Does your child enjoy being in the setting?
   _____ a great deal
   _____ most of the time
   _____ some of the time
   _____ not at all
7. Can we do anything for you in regard to other child care needs?

Time recorded / /

Coded _____

Problem # _____ I.D. # /_/_/_/_/_/_/_/

APPENDIX XXI

THE PROBLEM PAPER

1. Family Name _____ Child's Name _____

2. Child Care Setting: Name of Caregiver _____

Model Services	____	Center	____
Community Resources	____	Family Home Care	____
		School-Age Program	____

3. Problem Identified by:

Caregiver	____	Parent	____	Date _____
Setting Director	____	Child	____	
Coordinator	____	Other	_____	
Health Exam	____			
Developmental Evaluation	____			

4. During: a) Formal Follow-up ____ Informal Contact ____

b) With: Parent ____ Setting ____

5. Nature of Problem: _____

_____

_____

6. /_/ No follow-up required

7. Name of People Involved:

Name	Position or Organization
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

PROBLEM PAPER

APPENDIX XXI -- CONTINUED

8.

Action Taken	Result	Time Taken	By Whom

Total _____

Entered on time record _____

9. Problems in Obtaining Action:

_____ Parent hesistance
_____ Difficulty with appointment
_____ Needed service difficult to find
_____ Financial difficulty
_____ Bureaucratic hassle
_____ Transportation
_____ Parent difficulty with time off from work/school
_____ Other (explain) _____

Date: _____

10. Results:

_____ a) Needed resources obtained
_____ 1) Treatment in process
_____ 2) Appropriate termination of treatment
_____ 3) Inappropriate termination of treatment (explain)
_____
_____
_____ b) Resource not available
_____ c) Resource not accessible
_____ d) Other _____

11. Comments:

WHEN COMPLETED, ROUTE TO CCO.

Problem Expedited by _____

CCO-03

Request # _____

I.D. # ☐☐☐☐☐☐☐

APPENDIX XXII

REFERRAL/FOLLOW-UP

Family Name _____ Child's Name _____ Date _____

1. Short term _____ Long term _____

2. Referred to:

	Zip	Quality Rating	Called	Visited	Placement Made (date)
a. _____	_____	_____	_____	_____	_____
b. _____	_____	_____	_____	_____	_____
c. _____	_____	_____	_____	_____	_____

3. Comments on setting: _____

_____

_____

4. If no CCO placement occurred, are more referrals desired? Yes _____ No _____

a. _____ Placement no longer needed (e.g., plans changed).

b. Found placement without CCO assistance because:

_____ 1) another setting was suggested by someone else.

_____ 2) the need could not wait CCO process.

_____ 3) CCO process takes too much of parent's time.

_____ 4) CCO procedure is too much trouble.

_____ 5) Other (specify) _____

5. Short term placements:

Babysitting _____ Emergency _____ Other _____

Would you use this person again: Yes _____ No _____

6. Long term placements:

Setting: CR UCMC

Type: CCC FHC SAP

Research group: II IV V

7. Two children placed in same setting _____ Child under 2 _____

8. Placement was affected by:

Health information _____

Developmental information _____

9. Placement was in setting on which CCO had:

_____ a. No information.

_____ b. Questionnaire only.

_____ c. P.O.S.S.E.

Recorded time spent ☐

CODED —

UNIVERSITY OF COLORADO MEDICAL CENTER
4200 EAST NINTH AVENUE
DENVER, COLORADO 80220

COMPREHENSIVE CHILD CARE PROJECT
COUNSELING-COORDINATION OFFICE
UCMC BOX #2338
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FERN PORTNOY, M.ED., DIRECTOR
CHILD CARE CENTER

APPENDIX XXIII

NOTIFICATION TO CARE-GIVERS OF AVAILABLE SPECIAL SERVICES
FOLLOWING PLACEMENT CONFIRMATION

Dear

The Child Care Counseling-Coordination Office has interviewed the family whose name appears on the attached page regarding their child care needs. As part of the service offered by this office, we have checked through our child care resources and recommended that this family consider placing their child (children) in your child care setting.

Enclosed is a brief resume of our knowledge of the child and family. Naturally, the family is aware of the content of this letter.

A brief word about our Counseling-Coordination Office. We are part of a federally funded (Office of Child Development) Child Care Project. Our function is to maintain a resource bank detailing information on child care in the Metro Denver community and to make this information available to parents. Parents who are employees or students at the Medical Center visit our office to discuss their child care needs and we then help them to find child care which best meets their needs.

You will probably recall filling out a questionnaire or having a member of our staff visit you. It is based on the information you provided to us in the questionnaire or during our visit that we suggested your setting to this family. If there have been any significant changes, e.g., new program offerings, vacancies, changes in the number of children you can care for, please call the Counseling-Coordination Office and let us know so we may be in a better position to refer families to you.

This family will be involved in our follow-up program where in we have made ourselves available to assist the family with meeting needs other than child care. For example, families may wish a recommendation for a physician, or a lawyer, or may desire information on where to find a professional to provide them with consultation in a number of areas, e.g., psychological, social service, or financial. We would also

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APPENDIX XXIII-- CONTINUED

like to make this office and its staff available to you, the child care provider, in the event you feel this child and his/her family has needs for services we may help coordinate. Please do not hesitate to call if you have further questions or concerns about the child or family which we may be able to help you with. If we have not already done so, we would enjoy meeting you in person. A member of our Counseling-Coordination Office staff may be calling you in the near future to arrange for a visit and brief chat.

Cordially,

Fern C Pomroy

Fern C. Pomroy
Director
Counseling-Coordination Office

NOTES:

1. After December 31, 1973, families who complete the questionnaire will no longer be interviewed. Families following the Group IV path become Group VI families. Those following the Group V path become Group VII families.
2. After December 31, 1973, referrals will be given only after a vacancy search among settings has been conducted by CCO staff. Families following the Group II path become Group III families.

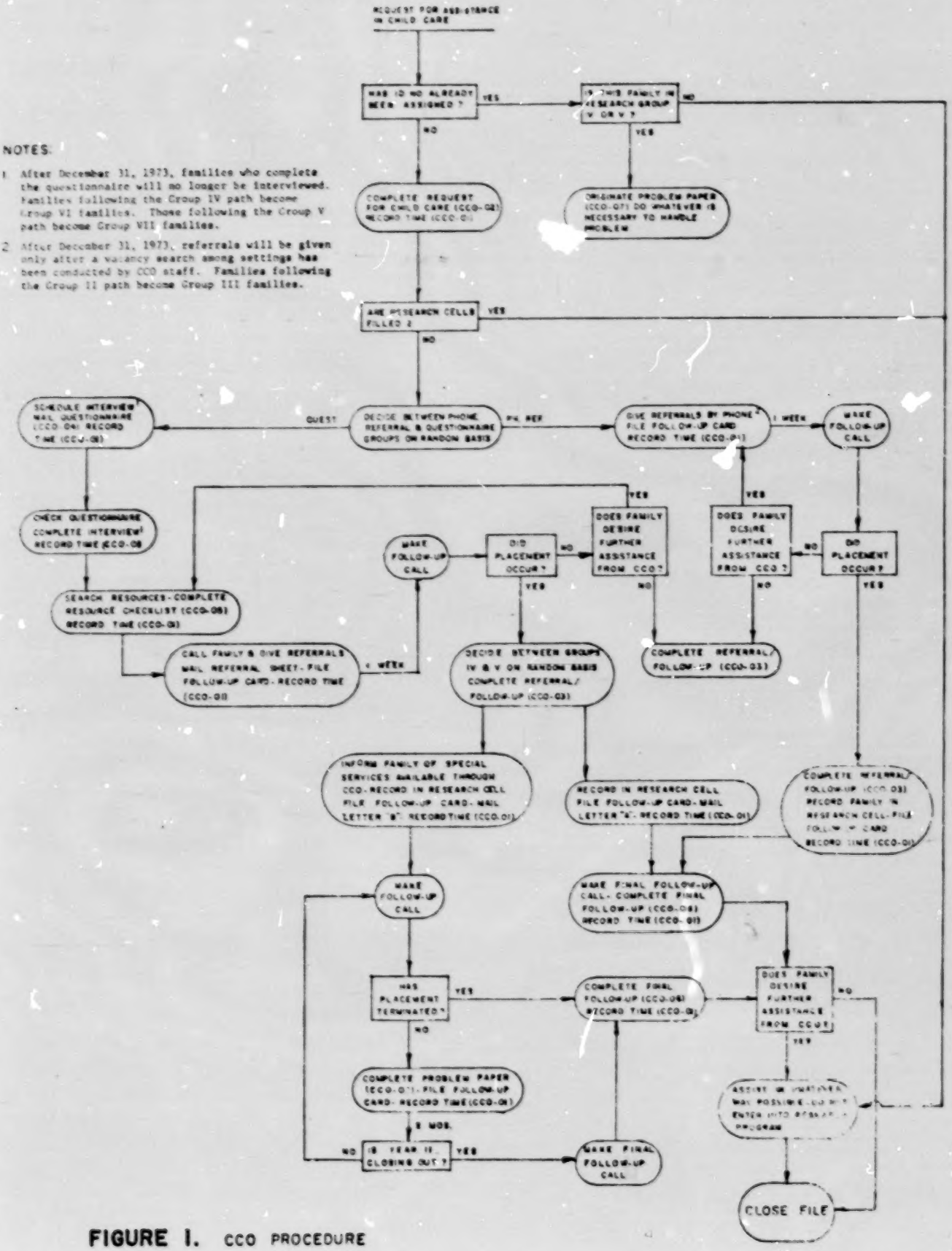
REQUEST FOR ASSISTANCE IN CHILD CARE
HAS ID NO ALREADY BEEN ASSIGNED ?
YES
NO
IS THIS FAMILY IN RESEARCH GROUP IV OR V ?
NO
YES
COMPLETE REQUEST FOR CHILD CARE (CCO-02) RECORD TIME (CCO-01)
ORIGINATE PROBLEM PAPER (CCO-07) DO WHATEVER IS NECESSARY TO HANDLE PROBLEM
ARE RESEARCH CELLS FILLED ?
YES
NO
SCHEDULE INTERVIEW MAIL QUESTIONNAIRE (CCO-04) RECORD TIME (CCO-01)
QUEST
DECIDE BETWEEN PHONE REFERRAL & QUESTIONNAIRE GROUPS ON RANDOM BASIS
PH. REF
GIVE REFERRALS BY PHONE FILE FOLLOW-UP CARD RECORD TIME (CCO-01)
1 WEEK
MAKE FOLLOW-UP CALL
CHECK QUESTIONNAIRE COMPLETE INTERVIEW RECORD TIME (CCO-01)
SEARCH RESOURCES - COMPLETE RESOURCE CHECKLIST (CCO-05) RECORD TIME (CCO-01)
CALL FAMILY & GIVE REFERRALS MAIL REFERRAL SHEET - FILE FOLLOW-UP CARD - RECORD TIME (CCO-01)
1 WEEK
MAKE FOLLOW-UP CALL
DID PLACEMENT OCCUR ?
NO
YES
DOES FAMILY DESIRE FURTHER ASSISTANCE FROM CCO ?
YES
NO
DOES FAMILY DESIRE FURTHER ASSISTANCE FROM CCO ?
YES
NO
DID PLACEMENT OCCUR ?
NO
YES
DECIDE BETWEEN GROUPS IV & V ON RANDOM BASIS COMPLETE REFERRAL/ FOLLOW-UP (CCO-03)
COMPLETE REFERRAL/ FOLLOW-UP (CCO-03)
INFORM FAMILY OF SPECIAL SERVICES AVAILABLE THROUGH CCO - RECORD IN RESEARCH CELL FILE FOLLOW-UP CARD - MAIL LETTER "B" RECORD TIME (CCO-01)
RECORD IN RESEARCH CELL FILE FOLLOW-UP CARD - MAIL LETTER "A" - RECORD TIME (CCO-01)
COMPLETE REFERRAL/ FOLLOW-UP (CCO-03) RECORD FAMILY IN RESEARCH CELL - FILE FOLLOW-UP CARD RECORD TIME (CCO-01)
MAKE FOLLOW-UP CALL
MAKE FINAL FOLLOW-UP CALL - COMPLETE FINAL FOLLOW-UP (CCO-06) RECORD TIME (CCO-01)
HAS PLACEMENT TERMINATED ?
YES
NO
COMPLETE FINAL FOLLOW-UP (CCO-06) RECORD TIME (CCO-01)
DOES FAMILY DESIRE FURTHER ASSISTANCE FROM CCO ?
NO
YES
ASSIST IN WHATEVER WAY POSSIBLE - TO RE-ENTER INTO RESEARCH PROGRAM
COMPLETE PROBLEM PAPER (CCO-07) - FILE FOLLOW-UP CARD - RECORD TIME (CCO-01)
2 WKS.
IS YEAR IT. CLOSING OUT ?
NO
YES
MAKE FINAL FOLLOW-UP CALL
CLOSE FILE

FIGURE I. CCO PROCEDURE

APPENDIX XXV

TABLE XV

OPERATIONAL DEFINITIONS OF TERMS

TERM	HYPOTHESES #	DEFINITION	SOURCE	INSTRUMENT	ITEM #
1. Stable Child Care arrangement	1. 1, 2, 3, 4, 6b, 7, 9a, 12	1. Duration of arrangement (time)	1. Referral Follow-Up Final Follow-Up	1. 03 06	1. 2 1
2. Single parent	2. 1, 1a, 1b	2. Other than married	2. Child Care Questionnaire (CCQ)	2. 04	2. 0
3. Parent employed	3. 1	3. Working full or part time	3. CCQ	3. 04	3. -, 3
4. Stable attendance pattern	4. 1a, 3a, 4a	4. Ratio of days attended to days enrolled	4. Model Service attendance and enrollment	4. 08	4. N/A
5. Illness	5. 1b, 1c	5. Out of setting -- parent reports child ill	5. Model Service illness and absence records	5. 09	5. N/A
6. Model Service settings	6. 1c	6. Child Care Center Family Home Care School Age Children	6. Coded on Attendance/Enrollment Problem Paper/Illness and Absence	6. 08 07 09	6. N/A 2 N/A
7. Problems with child care arrangements	7. 2	7. Parent report or caregiver report	7. Problem Paper Final Follow-Up	7. 07 06	7. 5 12
8. Extended family	8. 2	8. "Relative available" response to alternate care question	8. CCQ	8. 04	8. 8
9. Financial need	9. 3, 3a	9. Parent perception of	9. CCQ	9. 04	9. 7
10. Motivation for seeking	10. 3, 3a	10. Parent #1 stated reason	10. CCQ	10. 04	10. 7
11. Stress	11. 4, 4a	11. See list (One or more checked) Single parent status (alone) does not constitute stress	11. CCQ	11. 04	11. 14 16 22

TERM	HYPOTHESES #	DEFINITION	SOURCE	INSTRUMENT	ITEM #
12. Child's age	12. 5, 5a, 5b, 5c	12. Birthdate	12. Request for Child Care Service	12. 02	12. 4
13. Two children from same family	13. 5, 5a, 5b, 5c	13.	13. Request for Child Care Service	13. 02	13. 5
14. Failure	14.	14. Family seeking care where no CCO process placement occurs	14. Referral Follow-Up	14. 03	14. 2
15. CCO time	15. 5a, 5c, 6	15. Minutes CCO staff expends on process with given family a. Placement b. Follow-up	15. Time Sheet	15. 01	15. N/A
16. Effort	16. 5b, 6a	16. # of child care settings contacted before 3 or more choices obtained	16. Resource Check List	16. 05	16. N/A
17. Matching Process	17. 5c	17. CCO process with Groups IV, V, VI, VII (see pp.	17. Referral Follow-Up	17. 03	17. 6
18. Non-Matching Process	18, 5c	18. CCO process with Groups II, III	18. Referral Follow-Up	18. 03	18. 6
19. Experienced mother	19. 6, 6a, 6b	19. At least one child 24 mos. or older	19. CCQ	19. 04	19. 0
20. Inexperienced mother	20. 6, 6a, 6b	20. One child 12 mos. or younger or pregnant	20. CCQ	20. 04	20. 0
21. Experienced worker	21. 6, 6a, 6b	21. Working consistently for previous 24 mos. (other than maternity leave of 3 mos. or less)	21. CCQ	21. 04	21. 11

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TERM	HYPOTHESES #	DEFINITION	SOURCE	INSTRUMENT	ITEM #
22. Inexperienced worker	22. 6, 6a, 6b	22. Not been working for previous 24 mos.; has been on maternity leave for 3+ mos. during this period of time	22. CCQ	22. 04	22. 11
23. Involvement in CCO process	23. 8, 9, 9a, 10, 14	23. (See pp.	23. Referral/Follow-Up	23. 03	23. 6
24. Satisfied with with CCO process	24. 8, 12a, 13	24. Attitude of parents re: time, hassle; would they use CCO again, etc.	24. Final Follow-Up One-Shot Questionnaire	24. 06	24. 8, 9, 10
25. Satisfaction with child care arrangement	25. 7a, 9, 12	25. Does arrangement meet child's needs, parents' needs (time, expense, location). Is child happy?	25. Final Follow-Up One-Shot Questionnaire	25. 06 10	25. 4, 5, 6 8, 9, 1[illegible]
26. Quality of setting	26. 7, 7a, 7b	26. Subjective quality rating by Child Care Project personnel making site visits	26. Referral/Follow-Up	26. 03	26. 2
27. Knowledgeability	27. 14, 14a	27. Response to series of child care related issues	27. CCQ Final Follow-Up	27. 04 06	27. 12 11
28. Intervention	28. 14a	28. Groups V, VII (see pp.	28. Referral/Follow-Up Problem Paper	28. 03 07	28. 6 0
29. Delivery of Special Services as part of setting	29. 15, 15a,	29. Coordinator of Model Services initiates follow-up with families and model service settings	29. Problem Paper	29. 07	29. 2
30. Delivery of Special Services as part of referral system	30. 7b, 15, 15a, 15b	30. CCO staff initiates follow-up with families and settings	30. Problem Paper	30. 07	30. 2
31. Problems	31. 12b, 15, 15b	31. Anything causing concern or anxiety to parents, child or caregiver	31. Problem Paper	31. 07	31. 5

TERM	HYPOTHESES #	DEFINITION	SOURCE	INSTRUMENT	ITEM #
32. Problems resolved	32. 15a	32. Conclusion reached in problem solving process	32. Problem Paper	32. 07	32. 10
33. Placement	33. 5, 5c, 10, 11, 12	33. Family enrolls child in CCO recommended setting	33. Referral/Follow-Up	33. 03	33. 2
34. Information about setting	34. 11	34. Site visit (P.O.S.S.E.) vs. Questionnaire only vs. No information	34. Referral/Follow-Up	34. 03	34. 9
35. Smaple group	35. 12, 12a, 12b, 13	35. Process treatment (see p. 2)	35. Referral/Follow-Up	35. 03	35. 6